

HEALTH EFFECTS OF THE VIETNAM WAR— THE AFTERMATH

HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED ELEVENTH CONGRESS SECOND SESSION

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HEALTH EFFECTS OF THE VIETNAM WAR— THE AFTERMATH

WEDNESDAY, MAY 5, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Michaud, Herseth Sandlin, Hall, Perriello, Teague, Rodriguez, Donnelly, Walz, Adler, Stearns, Boozman, Bilbray, and Roe.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. The Committee on Veterans' Affairs will come to order.

I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks. Hearing no objection, so ordered.

I believe it is appropriate that as we talk about the Vietnam War today, that we mention the Vietnam veteran tee-shirt vendor who first alerted us to the car that had bomb material in it in New York City. He is the President of the Vietnam Veterans of America (VVA) Chapter 817. We want to add our thanks, the Nation's thanks to this Vietnam veteran who may have saved thousands of lives.

Thank you all for being here this morning. The purpose of today's hearing is to examine the health effects that our veterans sustained during the Vietnam war as a result of being exposed to the toxic dioxin-based concoctions that we now generally refer to as Agent Orange.

As such, we will follow-up on the U.S. Department of Veterans Affairs' (VA's) long outstanding promise to conduct a National Vietnam Veterans Longitudinal Study, the NVVLS. We ought to stop the stovepiping in VA and look at how all of these issues relate to providing benefits for presumptive conditions under current law for Agent Orange combat veterans.

I want to ensure that we do not leave any of our veterans who were exposed to Agent Orange while fighting overseas uncompensated for their injuries and left behind due to VA technicalities.

It has been 10 long years since Congress mandated that the VA study the long-term, lifetime psychological and physical health impact of the Vietnam War on the veterans of that era.

In 2000, Congress required that the VA conduct this longitudinal study by building on the findings of the National Vietnam Veterans Readjustment Study in 1984. That study was a landmark report, which provided a snapshot of the psychological and physical health of Vietnam veterans.

A follow-up longitudinal study, of course, is needed to understand the life course of health outcomes and comorbid events that have resulted from the traumas our men and women endured during the Vietnam War.

Initially the VA adhered to the letter of the law, but halted the NVVLS study in 2003 by not renewing a 3-year, noncompetitive, sole-source contract that they awarded in 2001. The VA cited cost reasons, noting that the original estimate for completing the study had ballooned from \$5 million to \$17 million.

The VA took no further steps and ignored the law until this Committee received a proposal from former Secretary Peake in January of 2009. The Secretary recommended substituting the NVVLS with a study of twins who served in the Vietnam War and a study of women Vietnam War veterans, which would cost around \$10 million.

Given the cost of the alternative option, it seemed to me that the VA could have completed the original study on time had the Department chosen to allocate the \$10 million to the original contract award back in 2003.

This Committee and others do not see the merit of the alternative proposal and has continued to advocate for the completion of the original study that was mandated.

In September 2009, Secretary Shinseki committed to carrying out this study. And, while I applaud the Secretary for his commitment, I remain very vigilant about the issue.

In today's hearing, I would like to better understand the progress that VA has made in conducting the study. I also hope to learn about the potential barriers that we can proactively address so that the VA remains on track to complete the study.

Also, Congress passed several measures to address disability compensation issues for Vietnam veterans. The Veterans Dioxin Radiation Exposure Compensation Standards Act of 1984 required the VA to develop regulations for disability compensation to Vietnam veterans exposed to Agent Orange.

In 1991, the Agent Orange Act established, for the first time, a presumption of service-connection for diseases associated with herbicide exposure. The Agent Orange Act authorized the VA to contract with the Institute of Medicine (IOM) to conduct a scientific review of the evidence linking certain medical conditions to herbicide exposure.

Under this law, the VA is required to review the biennial reports of the Institute of Medicine and to reissue regulations to establish a presumption of service-connection for any disease for which there is scientific evidence of a positive association with herbicide exposure.

However, apparently VA illogically backtracked on the Agent Orange Act regulations by reversing its own policy to move to require a foot on land occurrence by Vietnam veterans in order to prove service-connection. This means that the Vietnam Service Medals

and other such awards would no longer be accepted as proof of combat.

This change excluded nearly one million Vietnam veterans who had served in our Navy, Air Force, and in nearby border combat areas. This is an unfair and unjust result that has been litigated endlessly and ultimately against the veterans.

I am trying to undo this injustice in a bill that I have introduced called the Agent Orange Equity Act of 2009, H.R. 2254. More than a majority of the Congress has in fact, been added as co-sponsors to this bill and I urge everyone to become a co-sponsor.

Today, I hope to hear from the VA as to why it reversed its policy that now excludes our Blue Water servicemembers from presumptive consideration for service-connection and treatment.

I also want to know why it is ignoring the latest 2009 IOM recommendation that members of the Blue Water Navy should not be excluded from the set of Vietnam era veterans with presumed herbicide exposure. I know the VA has asked the IOM to issue a report on Blue Water veterans in 18 months, but that is 18 months too long.

The foot on land requirement is especially unreasonable when you consider that these servicemembers were previously treated equally to other Vietnam veterans for benefit purposes.

Moreover, several Australian Agent Orange studies long ago concluded that their Blue Water veterans who served side by side with our Blue Water veterans were exposed to Agent Orange and because of the water distillation process on the ships ingested it even more directly.

While I applaud the VA for recently adding three new presumptions for Parkinson's disease, ischemic heart disease, and B-cell leukemias for Agent Orange exposed veterans, those are three new presumptions for which Blue Water veterans may suffer and will not be treated or compensated.

I urge the VA to start compensating these veterans immediately. Just like it reversed the decision in 2002, I strongly urge VA to reverse back and compensate these deserving veterans.

Finally, I want to know for sure that VA plans to make the Blue Water veterans included in the NVVLS so that they and their families and survivors have a chance to get the benefits they deserve on equal footing with other Vietnam veterans.

I look forward to hearing from all of our witnesses today and thank you for being here to examine these long-standing issues.

I now recognize Mr. Stearns for an opening statement.

[The prepared statement of Chairman Filner appears on p. 49.]

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Good morning, everybody.

And thank you, Mr. Chairman.

I would like to welcome everyone here this morning for obviously a very important hearing on the health effects from the Vietnam War. The focus of this discussion is to further examine the negative health impact the war has had on our veterans.

Like many in the audience, I served during the Vietnam era and many of my colleagues were killed or suffered injuries.

We want to ensure that our government is taking every possible measure to alleviate the physical and mental health afflictions these men and women have faced since the Vietnam War ended 35 years ago.

Some veterans struggle today with post-traumatic stress disorder (PTSD), cancer, neurological disorders, and a number of other diseases that are associated with Vietnam and now they are suffering quite considerably. These veterans, so many years after the war ended, still fight their own battles every day. For some, the battle is with the intrusive memories of horrific events. For others, it is simply with the debilitating effects of diseases and their treatment.

Regardless of what they face, they should not also have to battle the VA for their benefits. Our government was far too slow in recognizing the effects of the Vietnam War on veterans. But from this lesson, we have improved diagnoses, treatments, and compensation for our veterans.

Congress passed the Agent Orange Act of 1991 as part of this effort. The legislation directed the National Academy of Sciences to conduct a comprehensive review and evaluation of the health effects of herbicide exposure.

The Institute of Medicine completed the initial study in 1994 and conducted subsequent periodic reviews of evidence as it became available.

In these reviews, IOM evaluates scientific data to determine if there is a statistical association between various pathologies and exposure to herbicide agents.

If it is shown that there is an increased risk for particular disease among those veterans who were exposed and that there is a plausible connection between exposure and the disease, then VA has the authority to establish a presumptive service-connection.

We applaud Secretary Shinseki for recently utilizing this authority to add three new diseases to the VA's list of illnesses associated with exposure to herbicide agents. I understand the rule-making process is underway but that a number of steps remain before the final rule can take effect.

So I look forward to hearing from our VA panel today and getting an update on what needs to be accomplished and how soon veterans can begin receiving compensation.

Moreover, I am deeply concerned about VA's ability to handle the brunt of the hundreds of thousands of new claims it will potentially receive and the impact it will have on the unacceptable backlog that exists today for disability claims.

Besides cancers and other debilitating conditions associated with Agent Orange, many Vietnam veterans are haunted by lingering memories of their involvement in the war. And tragically upon returning home from Vietnam, many veterans were personally attacked by those who opposed the war. Such disrespect magnified the stress associated with their combat experiences and not surprisingly left many of our war heroes bitter and emotionally scarred.

Homelessness, substance abuse, and suicide are all too tragic problems that in many cases can be attributed directly to post-traumatic stress disorder. Unfortunately, so many of our veterans,

including Vietnam veterans suffering from PTSD, have shunned any involvement with the government including tragically, the VA.

A few years back, the VA along with several representatives from the VA, the veterans community, and community organizers visited a large veterans' encampment in my hometown of Ocala, Florida. This was part of a homeless veterans outreach program. It was discovered that some of the residents there were recipients of Purple Hearts and other combat awards who had never even sought VA benefits or care because of their mistrust of the United States Government.

Fortunately, these veterans agreed to receive the assistance they had earned through their service. Sadly, there are still many more who remain isolated from VA and the care that is available to them.

Over the past several years, VA has expanded its outreach efforts and the number of veterans receiving compensation for PTSD has grown dramatically.

VA has also recently provided a regulatory change that more closely reflects the intent of Congress to provide due consideration to the time, place, and circumstance of a veteran's service. This change will facilitate the timely resolution of PTSD claims and provide compensation to those who suffer as a result of their service to our country.

So I applaud the VA for this and the other steps it has taken on behalf of Vietnam veterans, but I am sure we all recognize that much remains to be accomplished and that is the purpose of our hearing today.

I look forward to the testimony of our panels today, for this very important discussion.

And I thank you, Mr. Chairman, for this hearing.

The CHAIRMAN. Thank you, Mr. Stearns.

I now call our first panel. We have watched for at least 40 years, the bureaucratic "movement" on this issue. It took more than a decade to even recognize the effects of Agent Orange and when it was recognized, the VA set up incredible bureaucratic hurdles for the veteran to get disability compensation. We have waited years and years for this longitudinal study.

It seems to me that our veterans have suffered enough. I think sometimes that veterans suffer more from fighting the VA than they probably do from their original injury or disease. Many people who have gone through this think VA means veterans' adversary instead of veterans' advocate. It seems to me that we ought to end this suffering.

As I mentioned, I have a bill, that honors all the Agent Orange claims as of today. People have suffered enough. All this bureaucracy about what is presumptive, what qualifies, and the requirement of boots on the ground just puts people through more suffering.

Not only should we honor those claims, but it would also help with the claims backlog that Mr. Stearns mentioned. I suspect there are a couple hundred thousand Agent Orange claims in the process. Let us just get those off the books.

It is not too late to say thank you for those veterans that we did not honor, as Mr. Stearns again pointed out, when they came

home. Let us not only say we are sorry as a Nation, but let us actually do something on their behalf.

I hope people will respond to my modest proposal.

If the first panel would please join us? Dr. Richard Fenske is the Professor and Acting Chair of the Environmental and Occupational Health Sciences at the School of Public Health and Community Medicine and he is here on behalf of the Institute of Medicine.

Dr. Charles Marmar is the Chair of the Department of Psychiatry at New York University Langone School of Medicine, and Mr. Randall Williamson is a Director of Health Care at the U.S. Government Accountability Office (GAO).

We thank you all for being here. Each one of you will be recognized for 5 minutes for an oral presentation and your complete written statement will be included in the hearing record.

We will start with Dr. Fenske. Thank you again for being here.

STATEMENTS OF RICHARD A. FENSKE, PH.D., M.P.H., PROFESSOR AND ACTING CHAIR, ENVIRONMENTAL AND OCCUPATIONAL HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH AND COMMUNITY MEDICINE, UNIVERSITY OF WASHINGTON, SEATTLE, AND CHAIR, COMMITTEE ON THE REVIEW OF THE HEALTH EFFECTS IN VIETNAM VETERANS OF EXPOSURE TO HERBICIDES, (SEVENTH BIENNIEL UPDATE) BOARD ON THE HEALTH OF SELECT POPULATIONS, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES; CHARLES R. MARMAR, M.D., CHAIR, DEPARTMENT OF PSYCHIATRY, NEW YORK UNIVERSITY LANGONE SCHOOL OF MEDICINE, NEW YORK, NY; AND RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF RICHARD A. FENSKE, PH.D., M.P.H.

Dr. FENSKE. Thank you very much, Chairman Filner, and good morning to Members of the Committee.

My name is Richard Fenske. I am at the School of Public Health at the University of Washington. I served as a member of the Veterans and Agent Orange (VAO) Committee established by the Institute of Medicine for updates 2002, 2004, and 2006 and then I became the Chair for update 2008. So I am here on behalf of the Institute of Medicine to briefly describe the process that we have used in those reports.

The National Academy of Sciences was chartered by Congress in 1863 to advise the government on matters of science and technology and the Institute of Medicine was established in 1970 by the National Academy to enlist the services of appropriate professionals to examine science and policy matters pertaining to the health of the public.

As has been said, Congress established a mandate for a series of veterans and Agent Orange reports in the Agent Orange Act of 1991 and the legislation directed the Secretary of Veterans Affairs to have the National Academy of Sciences perform a comprehensive evaluation of scientific and medical information regarding the health effects of exposure to the herbicides used in Vietnam and it called for an update every 2 years.

Agent Orange was only one of several herbicide mixtures used in Vietnam. The name refers to the color band on the herbicide barrels. Agent Orange was a mixture of the phenoxy herbicides 2,4-D and 2,4,5-T.

In addition to other herbicides, picloram and cacodylic acid were applied in Vietnam and a dioxin compound known as TCDD was an unwanted contaminant in the 2,4,5-T herbicide, so dioxin-like chemicals have also been considered in our Committee reviews.

The legislation from 1991 directs VAO Committees to evaluate the evidence of statistical associations between specific health outcomes and exposure to the herbicides used by the military in Vietnam. The legislation does not ask the Committees to establish causality, which generally requires a more stringent standard of evidence. This charge is in keeping with judicial history related to Agent Orange exposure.

In reaching consensus about an association between exposure and health effects, the Committee considers only peer-reviewed, published scientific literature. VAO Committees have viewed epidemiologic studies of Vietnam veterans to be central to their decision-making, working on the assumption that service in Vietnam was a proxy for exposure at levels in excess of what would have been experienced by nondeployed individuals.

The Committees have also drawn upon relevant epidemiologic studies of other exposed populations and much useful information has come from these nonveteran studies.

The original VAO Committee established a set of categories of association for adverse health outcomes. A chart with these categories has been provided in my written testimony.

The starting point or default category is inadequate or insufficient evidence of an association. Any health outcome that is not explicitly listed falls into this category.

Health outcomes that appear to be associated with exposure are placed in one of two categories, either of sufficient evidence or limited or suggestive evidence. There is not a discrete dividing point between these categories, so the choice depends on the number, the strength, and the consistency of the studies that indicate increased risk as well as consideration of factors like bias and confounding.

Since Committee decisions focus on statistical associations, the placement of the health outcome in the sufficient category does not necessarily imply that a causal relationship has been established between exposure and disease.

The original VAO Committee also established a category of suggestive evidence of no association. But over time, Committees have decided to move all but one health outcome from this category into the default category of inadequate or insufficient evidence since it is very difficult to determine that there is really no association.

The summary chart details those health outcomes that have been placed in the sufficient or the limited or suggestive evidence categories and it also indicates the year of the VAO finding and any subsequent adjustment.

The most recent VAO Committee update 2008 reviewed the scientific literature published from October 2006 through September 2008. We moved two conditions, Parkinson's disease and ischemic heart disease, to the limited or suggestive evidence category. We

also concluded that hairy cell leukemia and chronic neoplasms belong with chronic lymphocytic leukemia in the sufficient evidence category.

That concludes my testimony. Thank you. And I will be happy to answer questions.

[The prepared statement of Dr. Fenske appears on p. 52.]

The CHAIRMAN. Thank you.

Dr. Marmar.

STATEMENT OF CHARLES R. MARMAR, M.D.

Dr. MARMAR. Good morning, Chairman Filner, Congressman Stearns, and Members of the Committee.

Nearly 25 years ago, Congress enacted Public Law 98-160 directing the Veterans Administration to arrange for an independent scientific study of the adjustment of Vietnam veterans. The purpose of that study was to provide an empirical basis to formulate policy related to veterans' psychosocial health.

In response to this mandate, the National Vietnam Veterans Readjustment Study or NVVRS was conducted. I was fortunate to have served as a member of the NVVRS research team. The survey component of the study was conducted in 1986 and 1987 with a nationally representative sample of all who served in Army, Navy, Air Force, and Marines during the years of the war.

Findings from the NVVRS were an important ingredient in the mix of social and political forces that brought about major changes in VA policy towards post-war readjustment problems of Vietnam veterans and other veterans and in the public's understanding and acceptance of the concept of PTSD.

For the past 13 years, I have been Chief of Psychiatry at the San Francisco VA where I have had a chance to implement many of those important findings into clinical care policy.

Briefly what were the major findings from the NVVRS? At the time study was conducted in the late 1980s, the majority of Vietnam theater veterans had made a successful reentry into civilian life speaking to their resilience.

However, an important minority, nearly one in three, met criteria for PTSD related to their war-zone deployment at some time following their service and strikingly half of the men and one-third of the women who ever developed war-zone PTSD continued to suffer with the disorder a decade or more following the conclusion of the war.

Those with PTSD had higher rates of depression, alcohol and drug abuse, problems affecting work, family relations, and physical health. Families of veterans with PTSD have been affected with problems in marital adjustment, parenting skills, interpersonal violence, and children were affected with more adjustment behavioral problems.

Finally and importantly, at the time the survey was conducted in the late 1980s, most Vietnam veterans had never used the VA for mental health services. There has been controversy about this study.

In 2006, there was an important re-analysis done based on the use of military records to validate combat exposure. The major findings from that re-analysis were that there was, one, little, if

any, falsification or dramatization of combat exposure. Overall, rates were found to be slightly lower at one in five rather than one in three veterans being affected. But I think it is important to also note that the study excluded as current combat PTSD cases anyone with a pre-military diagnosis of PTSD and we know that pre-military PTSD is a risk factor for developing war-zone PTSD.

I would like to speak briefly to the imperative need to conduct a long-term follow-up to the NVVRS, that is the NVVLS. Because of the high rates of PTSD, the strong evidence for the persistence of this syndrome, its strength of association with war-zone stress exposure, it is imperative that VA have information about the current functioning of the participants in the original study in order to make projections about how the entire Vietnam generation is functioning today because of the representative nature of the sample.

What would the NVVLS accomplish? As has been noted by the Chairman, there was a law in 2000 requiring the study to be conducted, but what would be the major benefits?

One, provide important information about the current functioning of veterans of the Vietnam War 20 years downstream from their Vietnam experience. Of great interest would be an understanding of how new cases form, how some people have recovered, and what the course has been over time as well as the possible impact of VA programs on effecting the recovery of Vietnam veterans with PTSD.

I want to emphasize that the NVVLS provides an unparalleled opportunity to determine if and how war-zone related PTSD is a risk factor for physical health problems. There are very great reasons to be concerned, that chronic post-traumatic stress increases the risk for high blood pressure, diabetes, heart attacks, stroke, and even possibly dementia. This study would answer those questions.

Determine the long-term impact of war-zone deployment on spouses and families and determine what has happened with respect to mental health care utilization, barriers to care, and satisfaction with VA health services, as well as to plan for future services for aging veterans.

Finally, the importance of the NVVLS must be placed in the context of the current readjustment of Iraq and Afghanistan veterans. To date, an estimated 1.9 million American men and women have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) and they are at risk for similar problems suffered by the Vietnam generation.

There is an urgent need to plan for their long-term adverse health consequences of OEF and OIF and these are underscored by recent studies showing a substantial minority of veterans from this new conflict are suffering from the same problems, PTSD, depression, alcohol and drug abuse, and risk of heart disease.

The NVVLS will generate critical knowledge about risk and resilience, course and complications of war-zone related PTSD on veterans and their families. This knowledge will serve as a blueprint for better preparing for the readjustment needs of those serving in Operation Enduring Freedom and Iraqi Freedom as well as for our aging Vietnam veterans.

Thank you.

[The prepared statement of Dr. Marmar appears on p. 55.]

The CHAIRMAN. Thank you, sir.

Mr. Williamson.

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Good morning, Mr. Chairman and Members of the Committee. I am pleased to be here today as you discuss the VA's National Vietnam Veterans Longitudinal Study, which I shall refer to as the NVVLS.

This study, which the Congress mandated VA to conduct in 2000, is intended to be a follow-on study to an earlier comprehensive study that VA completed in 1988 on post-traumatic stress disorder and related post-war psychological problems among Vietnam veterans.

Experts estimate that as many as 30 percent of Vietnam veterans may have experienced PTSD and currently Vietnam era veterans constitute the largest group receiving VA care for PTSD.

In my testimony today, which is based on our report released this morning for the Committee, I will discuss VA's recent progress in conducting the NVVLS and the challenges it faces in this regard.

VA's early progress on the NVVLS was slow. After the Congress mandated that VA conduct the NVVLS in 2000, VA awarded a contract in 2001 to an outside contractor for this follow-on study.

However, in 2003, before data collection for the study began, the study contract was terminated and VA's Office of Inspector General (OIG) later found that VA did not properly plan or administer the contract.

Thereafter, efforts to restart the study in earnest languished until September 2009 when the Secretary of Veterans Affairs announced that the Agency planned to award a new contract to an outside entity to conduct the NVVLS.

Since September 2009, VA has taken or plans to take a number of important steps towards conducting the NVVLS. VA convened a project team for the NVVLS consisting of VA officials and PTSD experts within VA and outside of VA. According to VA officials, the NVVLS project team developed a draft performance work statement, which outlines VA's requirements for the contractor.

VA expects to issue a request for proposals soon and select a contractor for this study this summer. VA officials say the study will be completed in 2014.

Conducting the NVVLS study is not without challenges, however. In conducting the NVVLS follow-on study, VA is required to use the same database and sample as the original study and address specific areas such as the long-term course and medical consequences of PTSD and whether particular veteran subgroups are at risk of chronic or more severe problems with PTSD.

One challenge pertains to locating prospective study participants and VA officials are unsure about how many veterans that participated in the first study will participate in the NVVLS.

The majority of researchers and methodologists we contacted—

The CHAIRMAN. I am sorry. I just cannot contain myself. You are reporting that the VA says it has problems finding these people?

Mr. WILLIAMSON. Well—

The CHAIRMAN. Any one of us can get you all the people you want. I do not understand. Well, you are not responsible, but, I can find as many veterans as you need. Ask the Vietnam Veterans of America. They will give you their list of members and you can start the study, right?

How many members do you have, Rick?

Mr. WEIDMAN. Sixty-two thousand.

The CHAIRMAN. I can find them in 5 minutes so I do not know why the VA has so much trouble. This idea that the study can't start until 2014 is because they are having a study of how to do the study. This is just ridiculous. I think we should end it all and just give everybody their benefits.

Mr. WILLIAMSON. And I am just reporting what VA told us.

Well, the majority of researchers and methodologists that we contacted within and outside of VA said that while locating participants from the first study is a formidable challenge, it is doable. They offered a number of suggestions such as data sources and methods that could be used.

Another challenge involves gaining consent from prospective participants. Virtually all researchers and methodologists we contacted thought it was important that NVVLS participants receive assurances of confidentiality as a condition of participating.

However, VA has not yet given such assurances and plans to take possession of all data including data identifying participants at the conclusion of the study.

VA officials said that participation in the study will not affect participants' VA benefits or VA health care.

The bottom line is that VA officials told us that they do not know whether the NVVLS can be completed given the challenges they face.

During the initial phase of the study, VA expects the contractor ultimately selected to assess the feasibility of the NVVLS. In doing so, we believe it is critical that the contractor and VA thoughtfully address the challenges that VA has told us about and thoroughly assess potential ways to mitigate them.

What is clear is this. Virtually all the experts with whom we had detailed discussions agreed that starting and completing the NVVLS soon is important not only because potential participants are aging but also it provides insights for treating PTSD not only for Vietnam veterans but for future generations of veterans as well.

Mr. Chairman, that concludes my remarks.

[The prepared statement of Mr. Williamson appears on p. 61.]

The CHAIRMAN. Mr. Stearns just pointed out that all my anger management sessions have been destroyed by your testimony.

Mr. Hall.

OPENING STATEMENT OF HON. JOHN J. HALL

Mr. HALL. Thank you, Mr. Chairman and Ranking Member Stearns.

And thank you to our panelists for your testimony.

I would like to join the Chairman in praising the efforts of two Vietnam veterans whose brave actions this weekend saved many lives in Times Square. Today Duane Jackson and Lance Horton are

once again heroes and true examples of the remarkable character of the men and women who wear the uniform of our country.

I have the honor of representing Mr. Jackson in Congress and I am sure that I join everyone here today in extending our thanks to him and Mr. Horton for choosing action over inaction. And that is what our soldiers and veterans have been trained to do and their quick thinking as well.

The subject before us today is vitally important. The war in Vietnam may have ended 35 years ago, but Vietnam veterans have not stopped suffering at that point. They continue to this day. And the fact that we need to have this hearing speaks to the inaction, the decades of inaction, dishonesty, and willful ignorance regarding the devastating impacts of both Agent Orange and PTSD.

It is clear that we need more research on the long-term health effects that were suffered by Vietnam veterans. I commend the work of the Institute of Medicine, especially their recommendations last year that found three new diseases that are associated with Agent Orange. This will help thousands of sick veterans access the health care and benefits that they deserve.

Unfortunately, I also find these reports to be limited because they only consider existing research. VA bills itself as a world-class health research institution. Why is VA not directing more of its resources or sponsoring independent research to study the full impact of the health crisis the U.S. Armed Forces created for its own servicemembers, our fellow citizens?

In 1991, Congress established guidelines for the VA to determine scientifically if a particular illness or disorder is associated with Agent Orange. In a claims system that is supposed to be nonadversarial, Congress tilted the standard of proof even further in favor of veterans. However, Congress was not able to slay the one enemy that still plagues our vets and that is inertia.

By not mandating new research focused on the health impacts of Agent Orange, Congress gave the VA the means to stall benefits for thousands of veterans. I think it is time for Congress to revisit that decision and also to acknowledge and for the VA to acknowledge that Agent Orange exposure goes far beyond those who set foot on Vietnamese soil, which is why I support the Chairman's Blue Water Bill, H.R. 2254, an important step in the right direction.

Veterans who served in Guam, Thailand, and even air bases in the U.S. may have been exposed to toxic herbicides. Establishing their exposure might be difficult, but we owe it to them to raise this issue.

I strongly support restarting the National Vietnam Veterans Longitudinal Study 8 years after Congress mandated it. I am interested in learning the VA's response to the GAO findings.

And this weekend, I was reminded of the hurdles still facing veterans with PTSD. There was an Associated Press story that took a tiny sample of fraud cases and blew them out of proportion in my opinion to imply that it is too easy for veterans to obtain their benefits for PTSD. I suspect that many in this room would find that laughable. And, of course, the opposite is true.

Just this week, I sat down in my district and spoke with a Vietnam veteran, sat at his kitchen table and talked about his case

which dragged on for years until my office got involved, at which point we were quickly able to get him 100 percent disability rating for PTSD from his service in Vietnam four decades ago.

While I am proud to help him, Mr. Berkowitz had earned those benefits and it is unacceptable that he had to wait so long and also that he had to come to his Congressman to get that help.

The VA should automatically have a system for granting reasonable claims without having to have a Congressional office get involved because there is not enough of us to do that work. Congressmen are not going to solve the claims backlog personally by taking on every one of these hundreds of thousands of cases. It has to be done by the VA.

So the topics covered here are extremely important. And I have used most of my time in a statement, which I will end and just ask a question perhaps for each of our panelists and submit more questions in writing if that is acceptable.

[The prepared statement of Congressman Hall appears on p. 50.]

Mr. HALL. I would like to ask your opinion on the VA's proposed rule change to create a presumption of service-connected disability for veterans diagnosed with PTSD, which I have a bill, H.R. 952, which just passed this Committee unanimously and is waiting for floor action. And the VA has proposed to do a rule change that would accomplish much of the same thing.

Do you believe that these changes are supported by the statistical evidence and the NVVRS and other studies? Dr. Fenske?

Dr. FENSKE. Well, I am afraid I have not really studied that area of the mental health aspects, so I would defer to Dr. Marmar.

Dr. MARMAR. It is a difficult area. I would say in overview, the available evidence suggests that the large majority of Vietnam veterans when asked about either their symptoms of psychiatric distress related to PTSD, nightmares, flashbacks, startle reactions, or their actual details of their war-zone experience, where they served and what they were exposed to in combat in the theater, that the vast majority are truthful in their reports.

Second, I think it should be emphasized that while occasionally there may be individuals for whatever reasons who dramatize their suffering following combat exposure, there is also a large number of men and women who serve in the military and in other important roles in our society who are reluctant to disclose their psychiatric problems because of reasons for stigma.

So, in fact, the dangers of under-reporting of psychiatric distress may well be greater than the dangers of over-reporting. So in general, I would say the majority of people seeking compensation do so for truthful reasons.

Mr. HALL. Mr. Chairman, if Mr. Williamson could answer, then I would yield back.

Mr. WILLIAMSON. I cannot address that. I am not up on that issue.

Mr. HALL. Thank you.

The CHAIRMAN. Thank you, Mr. Hall.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Dr. Fenske, when we start talking about threshold of benefits, the criteria that is used involves a couple of statistical associations.

And I just think the Committee needs to understand those thresholds and this goes to a little larger question when the Chairman says he would like to get everybody who is suffering have the benefits, but I think there should be some threshold level at which we understand whether a veteran is qualified.

Can you explain the difference between a “significant statistical association” and a “positive association” and a “sufficient association?” These evidently are statistical terms that are used to determine the threshold. And I would like you to explain that briefly, I only have a small amount of time, as it relates to the presumption of service-connection for herbicide exposure. Does that question make sense to you?

Dr. FENSKE. Yeah.

Mr. STEARNS. Can you pull the microphone a little closer to you too?

Dr. FENSKE. Yes. I should turn it on too.

Mr. STEARNS. Yeah. Turn it on. That is the problem, yes.

Dr. FENSKE. Threshold, well, yes. So in terms of the categories that we use, these were, it is on here, but—well, I will just speak up—established by the first Committee back in 1992. And we have used them. I think they have held up very well. They are very similar to the categories that are used by the International Agency for Research on Cancer, which has to classify chemicals.

Mr. STEARNS. Can you just hold and find out what the problem is.

The CHAIRMAN. We are going to try to fix the microphones.

Mr. STEARNS. Mr. Chairman, perhaps I can put this into a way that you can answer yes or no.

Should these three statistical things be continued to be used as thresholds or are they obsolete? In other words, when you talk about a significant statistical association, are these sufficient now to determine a threshold or should they be sufficient, some additional statistical—I guess I am trying to understand. Do we have in place the right thresholds? That is the question. Yes or no?

Dr. FENSKE. Well, I think the categories we are using are the right categories, yes. As far as determining whether or not there should be benefits associated with a disease that is put in one of those categories, that is up to the VA. That is not part of the Institute of Medicine’s charge.

Mr. STEARNS. So you say these thresholds are the problem? Are they working?

Dr. FENSKE. Yes.

Mr. STEARNS. Does someone have to make a subjective interpretation or is it very quantitative that comes from the statistical? Is it something that when I see it, I know it and it means something or is it very subjective?

Maybe the other panelists would like to help us out. It is a rather technical question. What I am trying to understand is if it is subject to luck?

Dr. FENSKE. In a particular study, we review many, many studies, and in any particular study, it is very quantitative. We talk usually about relative risk and confidence intervals and this provides us with evidence essentially yes or no as to whether a study demonstrates an association.

When we do our evaluation, we look at many studies and so we look at combinations of studies and we look at weaknesses in studies. So those judgments can be qualitative. So there is a mixture of quantitative and qualitative.

Mr. STEARNS. Okay. Thank you.

Mr. Chairman, I would probably just request additional time just because the speaker went out if you do not mind.

Dr. Marmar, how satisfied are you with the VA's recently announced plans to complete the longitudinal study after sort of the failure there as required by law and do you believe that they will meet the established timeline?

Dr. MARMAR. Well, it is difficult for me to answer that question on behalf of VA. Perhaps that is a better question for Dr. Kupersmith to address in his role in directing research at VA.

But as someone who has spent the last 13 years as the Chief of Psychiatry at the San Francisco VA and now is outside of VA, but following this with great interest, I would say that moving forward at this point along the lines that has been suggested by yourself and the Chairman is the right thing to do. It is realistic. The contracting can be accomplished.

And none of the obstacles that have been raised at this morning's discussion, whether locating subjects, guaranteeing confidentiality, or other aspects, none of those are obstacles that would prevent the timely conduct of the study.

So the short answer is it is feasible to do the study. It is urgent to do the study and the time frame for doing the open contract and accomplishing the goal by 2014 appears reasonable to me.

Mr. STEARNS. Dr. Marmar, I am just looking from the outside. It looks like 2014 is too long. I mean, they started the study. They stopped it. They knew what the objectives were. They know what the problem is.

Why would it take 4 years to do a study in your opinion? I guess a larger question is, could we do it in a shorter amount of time than 4 years?

Dr. MARMAR. It is possible to fast track it. I would say—

Mr. STEARNS. Not fast track it. I mean, it seems like 4 years is 4 years and they have all the data. And they also have been through one race on this and they did not accomplish it.

Dr. MARMAR. Some work was accomplished during that time.

Mr. STEARNS. Yes. So they can build on whatever they had.

Dr. MARMAR. Yes. I would say to implement this study, to complete all of the human subjects' requirements for this study, to locate and evaluate all the subjects, to make the important—

Mr. STEARNS. So the bottom line is you think they need 4 years?

Dr. MARMAR. I think if the study is to be comprehensive with regard to both the psychological and most importantly adverse physical health effects of serving in Vietnam, it will take 2 to 4 years.

Mr. STEARNS. Okay. Okay. Mr. Chairman, I think the Committee should get a report in less than 4 years, that we find out what they are doing, a draft form of some report. I do not think we should wait 4 years to see what happens. Just my suggestion.

I would like to ask Mr. Williamson my last question.

Mr. Williamson, you know, you are with the U.S. Government Accountability Office. What is your opinion? Do you think the VA

can meet the challenges they face with this longitudinal study and can it be accomplished in 4 years or give me your feeling on some of what Dr. Marmar—

Mr. WILLIAMSON. Well, we contacted 10 researchers and three methodologists who are experts in PTSD and experts in doing studies of this nature. And, yes, they think that all the challenges that the VA told us about are not insurmountable. There are ways to do the study.

It takes a can-do attitude. And, quite frankly, until recently I do not think VA has had the will to do it.

Mr. STEARNS. So you are saying that VA did not have a “can-do” attitude? Is that what you are saying?

Mr. WILLIAMSON. Well, I mean, it has been 10 years since the law passed.

Mr. STEARNS. That is your perspective. I mean, somebody has got to say something here.

Mr. WILLIAMSON. Yes.

Mr. STEARNS. And do you think that has changed?

Mr. WILLIAMSON. I think under—

Mr. STEARNS. What has happened that made a change?

Mr. WILLIAMSON. I think under the new Secretary, it appears that it has.

Mr. STEARNS. And what has happened to make a change in your opinion?

Mr. WILLIAMSON. I think coming to the Committee for one and getting Chairman Filner to—

Mr. STEARNS. Okay. Yeah.

Mr. WILLIAMSON. Yes.

Mr. STEARNS. I would just urge that the Committee ask for an interim report so that we do not sit here dumbfounded in 2014.

The CHAIRMAN. I am sick of the reports since they are rarely ever completed on time. The question really is, how many people will die between the interim and the report? This has gone on forever.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

I want to also congratulate you on staying on this subject and for moving forward. This just brings to light the need to do additional areas of study.

I know one of the things that has concerned me is the numbers, and I have some friends included in this, that when they came back from Vietnam, they got involved with drugs and part of it, I assume, was, due to self-medication because of what they were dealing with, and I would hope that maybe we can also look at additional studies and assessments as to how deal with this.

Additionally, I really believe we might have a case here, and although I do not have any proof of this, I would like to know if in the future, Mr. Chairman, we could look at how many of our veterans may have gone into our prison system, because of the use of drugs.

Second, and I do not know if any of you might want to comment; however, I know we have some new veterans coming home with the onset of PTSD now, as compared to those that have had it for 20 or 30 years. As said I would like to see if there are any different

approaches to treatment that we could come up with that respond to this immediate onset in PTSD that might be helpful versus the approaches used for those individuals that have been suffering from PTSD for 20 or 30 years, for example.

And if there are any of these studies doing this and, if not, I would like to see how we might approach this and be able to reach out more veterans and even put more resources in this area and get independent groups to do it and maybe not the VA, but other groups to do these studies separate from the VA. I believe this is, something that might make sense from a research perspective.

I was wondering if any of you would make any comments.

Dr. MARMAR. Yes, briefly. The NVVLS would not be primarily directed at the development of new treatments. It would make an assessment of which treatments may have been helpful or not over the course of Vietnam veterans' lives with PTSD.

Congressman, to answer your question briefly about there are major advances in the understanding and treatment of combat-related PTSD which need to be and are being delivered to Iraq and Afghanistan veterans, as well as those from other eras suffering from the more chronic form.

And in particular, there is research supported by VA, U.S. Department of Defense (DoD), and the National Institute of Mental Health to try to develop new treatments to help people at the time of battlefield exposure, to help them more quickly calm down so as they do not develop the chronic stress condition.

And, second, we now have safe and effective medications and behavioral treatments for treating PTSD in the first months after it occurs. To the extent that those are provided, we can prevent a lifetime of mental health disabilities.

Mr. RODRIGUEZ. Now, because you are not directly treating those soldiers that are out there, because you do not get to them until after they leave the military, what do we need to do to get to them since you indicated the research indicates the quicker we get to them, the better? Is that what you said?

Dr. MARMAR. Yes. That is what I am saying. And this involves—

Mr. RODRIGUEZ. How do we get to them since they are not with the VA at that point?

Dr. MARMAR. Right. Well, the DoD and the VA are in a partnership to answer that question. There has been a recent DoD Blue Ribbon Panel to try to answer that question and to develop best practices for how to manage combat stress and other problems in theater before the war fighters even become veterans.

Mr. RODRIGUEZ. I really would want for you to offer with the recommendations on this because serving 8 years on the Armed Services Committee, I know how a military leader or military person thinks and to them this might be secondary in terms of providing this support—their main goal is the mission and sometimes providing this access to the need of those soldiers might not necessarily be there.

This is very important for us to get as it points to what we might need to do from a Congressional perspective in this specific area. So I would, ask you to please get this to us.

And especially there is a need to do some, I hate to say this, additional studies here, but if that is the case or taking that soldier out for a certain period of time to help them. I know that we have had studies on this and we just have not done the right thing in the military. We have not taken them out when we should to give the soldiers help.

Dr. MARMAR. Well, just to briefly reassure you on this point, Congressman, this recent high-level Blue Ribbon Panel has made direct recommendations for improved war-zone treatment for combat stress and for traumatic brain injury (TBI). And these recommendations have been provided to General Amos from the Marines and General Corelli from the Army. They have the operational responsibility for their implementation.

Mr. RODRIGUEZ. And do you have any idea if they have been implemented?

Dr. MARMAR. I do not.

Mr. RODRIGUEZ. Okay. And we will never know unless you help us get these reports to us, so we can see what might need to occur. I think it is important for us to be on top of this situation.

The other thing is, Mr. Chairman, just to kind of look at other areas of the study and I will go back to those projects that we did in the 1960s and 1970s where we found 54 studies from—was supposed to have been 100, and make some assessments of those that also the military denied for 20 years until Congressman Thompson and the others uncovered them to see what we might be able to do to help out in those areas.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Rodriguez.

Mr. Roe.

Mr. ROE. Thank you, Mr. Chairman. Just a couple of comments and a couple of brief questions.

One, if this were not important, it would almost be laughable that you could go on a clinical trial, a clinical study for 11 years to get the results. Having been involved in clinical trials, if you have a will to do it, you get a matrix out there and you do the trial. And it looks to me like the VA was either—who was in charge of it or whatever just dropped the ball. I mean, there is no way in the world this should have ever happened.

And, Dr. Marmar, I totally agree with you and getting the information is critical because what happened at the end, and I am a Vietnam era veteran, what happened at the end of Vietnam was it was basically 20 years before anybody really—a lot of these men and women's lives were ruined because they were not treated.

And if we were studying cancer, this would be ridiculous when you are trying to get research and trial on that. And remember that last year, more veterans died of suicide than died of combat wounds and more. So it is a lethal problem. And to get this information you are talking about, it is exciting because if you can apply those treatments in theater or when they come back obviously, the warriors do, then you can change maybe the next 30 to 40 years of their lives.

So this longitudinal study ought to be done and it may not be able to be done in less than 4 years. A good clinical trial takes a

while, as you know, to get accurate data and then evaluate that data. So I agree with you. It should be done.

The excuse that it is hard to do is ridiculous. Of course good clinical trials are hard to do. If they were easy, this would have already been done. So just a couple of comments.

And I think your point you just made a minute ago has been the most important one here about effective treatment. If we get this information and maybe it is useful, I think we should follow these veterans the rest of their lives.

And that is exciting news right there that maybe the OEF and OIF veterans will not have the same outcomes that the Vietnam era veterans had because they will have early intervention.

A comment?

Dr. MARMAR. I just strongly agree. With regard to any health care problem, but specifically for the problems of PTSD and TBI which are of great importance in the current conflict, the critical thing is early intervention, access, and destigmatizing the problem so that the veterans have access to the treatment and they are willing to take them because the problem is if you take the sort of like PTSD in its early form, it is treatable and usually not disabling in its early form.

In its chronic forms, the dominos start to fall, alcohol, drugs, depression, marital problems, occupational instability, loss of income, homelessness. Those are a predictable set of dominos that fall if the disorder is allowed to progress into its end stage severe condition. So intervening early, aggressively, and in a way which does not undermine the confidence of the war fighter or the veteran is critical.

Mr. ROE. Thank you.

And Mr. Hall made a comment that somewhere he had read that they thought PTSD was overstated or whatever. I recommend you get shot at. We will see then if it is an issue. I think most veterans that have been out there and have been shot at realize it is real. I think it is real. Well, it is real. And certainly I appreciate your comments.

I yield back.

The CHAIRMAN. Thank you, Mr. Roe.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Marmar, my question is, since it has been quite some time since it was requested for the study, would you say that anything should be changed in the study or we should keep going the way it is or should we make some changes?

Dr. MARMAR. Well, I am very familiar with the study as it was originally designed in the early 2000s. I would say the study is fundamentally the correct design.

For the Committee, I would add only one important point. I think if we learned one thing dramatically new about the long-term adverse health effects of PTSD in the past 20 years it is that PTSD is not only extremely detrimental to a veteran's psychological functioning and family functioning, there is very considerable risk of adverse chronic health effects of living with PTSD over years to decades.

And specifically recent research from our group and others suggest that the risks of cardiovascular disease and the risks of diabe-

tes and the risks even of earlier and more severe onset dementia because of the chronic effects of stress hormones and other factors, stress is a killer. We have known for years that stress is bad on the heart, but we have not known until recently that PTSD could be dramatically associated with increased risk for heart disease, stroke, and even dementia.

And I would say it is of paramount importance that the NVVLS not change Vietnam veterans on a careful, in-depth assessment of the long-term adverse physical health consequences of their combat stress reactions.

Mr. MICHAUD. Okay. Thank you.

There are a number of Maine veterans who served in the National Guard and Reserves during the Vietnam time frame who were forced to conduct tactical herbicide training at the Canadian base, Gagetown.

Have the Canadians done any study on Agent Orange or Agent Purple and, if so, what is wrong with using what they have done for their studies?

Dr. FENSKE. Did you say—

Mr. MICHAUD. Anyone on the panel.

Dr. FENSKE. Did you say Canadian?

Mr. MICHAUD. Yes.

Dr. FENSKE. Canadian?

Mr. MICHAUD. Yes.

Dr. FENSKE. Well, one of the limitations of the work that we do for the Institute of Medicine is that we do not do any original research as has been pointed out. So we only review what is out there. And we have reviewed studies of Korean Vietnam veterans, Australian Vietnam veterans. I have not seen a study of Canadian Vietnam veterans.

Mr. MICHAUD. Because I believe the Canadian government actually are giving benefits to their soldiers who served in Vietnam because of Agent Orange. And so I know they had done some work at Gagetown. So I think it might be helpful if they have already done it, we might want to follow up on it.

Dr. FENSKE. Definitely.

Mr. MICHAUD. My other question is actually for the GAO. You mentioned the VA was reluctant and made excuses.

Has the GAO done any studies similar with Agent Orange with DoD or the U.S. Department of Health and Human Services because my concern is the same as Mr. Chairman and the Ranking Member? Four years is quite some time.

And if the study gets delayed and it is longer than 4 years, that will put us past the 2014 election or during the interim, you made a comment that the reason why this is good because Chairman Filner is moving forward. We have a Secretary who is willing to do it.

We do not know how long Secretary Shinseki is going to be there and if the new Secretary might decide to put it on hold again. So I think it is very important for us to move this forward not knowing what the outcome is going to come in 2012 or 2014.

Is there any way that the study can be moved up? Do we contract part of it out or do you find any way that it might be able

to move forward thinking outside the box? For Mr. Williamson or Dr. Marmar.

Mr. WILLIAMSON. Well, I would tend to agree with Dr. Marmar about part in terms of the clinical studies, but I am not really qualified to address that. I think he has addressed that already.

As much as we want to move this forward, I would take with a grain of salt the 2014 date. If you look at the twin study and the women's study, which were offered as substitutes for the NVVLS completion, those studies both have slipped 2 years from their original dates.

So I think that we have to be careful. And while we all want the 2014 date or sooner to materialize, there is certainly no guarantee of that.

Mr. MICHAUD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Boozman.

Mr. BOOZMAN. Mr. Williamson, in your testimony, you state the VA officials stated that they plan for the NVVLS to meet all the requirements of the law where scientifically feasible.

Can you expand on the statement? And let me just ask some things in regard to that.

Mr. WILLIAMSON. Okay.

Mr. BOOZMAN. Do you mean to imply that the VA may knowingly choose not to comply with some aspects of the law?

Mr. WILLIAMSON. No, it is not that. It is just that there are a number of challenges which I talked about in my opening remarks.

Again, locating the veterans is one. Now, regarding the failed NVVLS attempt in 2003, actually, we have talked to the co-principals that were involved in the NVVLS then and they actually did locate a large percentage of the veterans that participated in the original study.

Our discussions with the methodologists and researchers indicate they are very positive about data sources that can be used to locate veterans for this study. Gaining their consent is a big factor as well.

VA has talked to us about the measures to diagnose PTSD that were used during the original study and how those are very complex. Again, while they were very complex, and Dr. Marmar might be able to speak to this as well, certainly some of those same tools are used today. And I think VA plans to use a number of those tools again to the extent feasible.

But regarding feasibility, you know, one of the things that VA officials could have done and is typical for a lot of studies of this nature is to have maintained that database by updating addresses and sending newsletters and things that would have kept the database much more current. They chose not to do that over the last decade or more. And so that is going to make it more difficult—not insurmountable, but more difficult.

Mr. BOOZMAN. Do you, and the rest of your guys can chime in, do you see anything that we need to modify to the law to address any of the concerns that you have?

Mr. Williamson, again, you talked about some of these challenges. Do we need to modify the law in any way to help with any of the scientifically feasible challenges?

Mr. WILLIAMSON. In discussions with our methodologists and researchers—who are prominent PTSD experts across the country and within VA—there were no show stoppers that said we should modify the law. There may be possible refinements that could be made.

I think during the initial phase, after VA selects a contractor, they will assess the feasibility. And I think it is important that the Committee and all of us check in at that point in time to see what VA has concluded about the feasibility of the study.

Dr. MARMAR. The only thing I would add just to remind Members of the Committee since I was part of the original team that conducted the NVVRS in the mid 1980s, you can imagine at the time it was very challenging to locate the 3,016 participants in the study. The political climate was not as favorable as it is now. The public's understanding of PTSD was very immature compared to what it is now.

And the study was very successful using the tools that were then available to both identify and also to recruit and bring into the study the vast majority of those that were deemed eligible for the study. And now 20 plus years later, there are new tools available for identifying people, locating them, you know, the Internet, Google, other tools that were not available at the time.

And I think also Vietnam veterans as a group have galvanized and understand the importance of serving the country by re-upping or reenlisting, if you like, in this study. I believe the question of finding people, the participants and getting their commitment is not the major thing. The most important thing is to move quickly now with the law in its present form.

Mr. BOOZMAN. Okay. Very good.

Dr. FENSKE. May I make one comment?

Mr. BOOZMAN. Yes, sir. Sure.

Dr. FENSKE. I am not familiar with maybe some of the complexities of this particular study, but it is hard for me to understand why this is so complicated. I mean, at the University of Washington, we have dozens of studies that are following people. We have studies, you know, following people who were exposed to chemicals in the 1940s. And it does require keeping up with the records. And so if that has not been done, then that is an extra chore. But I cannot see why you would need to do a feasibility study to determine if you could do this study. I think you could just do the study.

Mr. BOOZMAN. Do the study.

Thank you, Mr. Chairman. That is a good point.

The CHAIRMAN. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

Dr. Fenske, could you give us a brief summary of your recommendations regarding Blue Water veterans, particularly in regard to definition of service in Vietnam?

Dr. FENSKE. Yes, I can. This was not a major point of our Committee's deliberations, but from the outset when these committees

started in the early 1990s, the Blue Water veterans were considered to be part of the exposed population.

And so when we reviewed studies, we have always included studies of those kinds. When we looked at this issue the last time around, given the information, particularly from Australia, there did not seem to be any good reason to be excluding them from a scientific point of view.

Mr. DONNELLY. Following up on that, what further study do you think is needed in regards to the Blue Water veterans and the question of Agent Orange?

Dr. FENSKE. Well, there is a new Committee at the IOM that is looking specifically at the question of the exposure of Blue Water Navy. And I think that they will be able to address that as well as anyone can. You know, there were not samples taken at the time, so it is always hard to reconstruct these things. But I think that that is going to provide the information that will be needed to answer that question.

Mr. DONNELLY. Do you know what kind of time frame we are looking at on that?

Dr. FENSKE. That Committee just started and I believe it has an 18 month time frame.

Mr. DONNELLY. Okay. And then, Dr. Marmar, based on what you have seen, is there anything else the VA can be doing right now to complete the NVVLS in a timely manner?

Dr. MARMAR. Well, again, I am not directly involved with the internal operations of VA research. So that is a question perhaps best for Dr. Kupersmith to address.

But just to come back to a point that was raised earlier about is there anything that we should be concerned about in terms of the scope of the study, the one thing again I would like to emphasize is that in the partnership between Congress and the VA and the study, that adequate resources be allocated for this study to ensure a high-level assessment of physical health consequences of long-term PTSD because at the end of the day, if that is not accomplished, a very large, very expensive study will have been conducted and one of the primary aims will not be fulfilled.

Mr. DONNELLY. Mr. Williamson, is there anything else you can think of that the VA can do to help complete this study in a timely manner?

Mr. WILLIAMSON. Well, I think one of the things we have not talked about, as I mentioned in my short statement, is that there were, as the Office of Inspector General for the VA noted, some very serious contract planning and administrative problems that existed, and VA has to avoid those in the future.

The OIG basically concluded in their report in 2005 that \$4.7 million, all of it or a substantial part of it, was wasted in that failed attempt. So VA, in addition to all the other things we talked about, has to administer this contract in a very responsible way.

Mr. DONNELLY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you all.

I have had many panels that I have been either upset with or angered at. You are the messengers and I am not angry at you. But talk about analysis paralysis—this is ridiculous.

We are talking about human lives here. We are sitting here talking about 4 more years when people are suffering. We ought to help the veterans first and then worry about all the studies.

Mr. Williamson, you said at one point in your testimony, that the VA said the study could be completed in 2013 and later, you said they are not even sure it can be completed. I do not know which is the right statement.

As Dr. Fenske pointed out, the first thing they are going to do is hire somebody to assess the feasibility of whether or not they are going to do it. I mean, this is ridiculous.

A few years ago, I was in Illinois and I was handed a list of several hundred Vietnam veterans, who got Parkinson's about 10 years earlier than you would expect them to get the disease. They were all around 50 years old. I do not need anything else—Parkinson's is related to Agent Orange. I am a layman, but I know that. It took how many years to say that it is presumptive?

I am sure Mr. Weidman has and could do a focus group of Vietnam veterans around the country. We could come up with all of the health problems that affect our veterans. I am confident that the anecdotal problems based on human suffering is more relevant right now than all these studies. You can do all these studies—I do not care how long they take—but let us end the suffering of all these people and grant their claims now.

I am sure that when Mr. Weidman gets to the witness table, he could tell us what could be presumptive because he has dealt with hundreds of people who have these ailments.

It is ridiculous that we are putting our veterans through this. It is depressing that we are going to have to go through these studies over numerous years. Let us get them their benefits and then we can worry about these studies.

Mr. Stearns said there is a true suffering here. If they have been applying for benefits and appealing their claim for 30 years, I do not care what they have, we should grant their claim. If there is a small percent of fraud, to reach the 98 percent who are actually suffering, I think we have to do it anyway.

I am just amazed that we have allowed this kind of procrastination for 30 years. We should take this away from the VA because it took them decades to even say that Agent Orange could cause adverse health effects. It took them decades to figure out some of the presumptions. Now we still have study after study.

What more proof do we have that they are incapable of doing it? Mr. Hall used the word willful ignorance. I think that is what is going on here. If they wait long enough, everybody will die and they will not have to spend any money trying to help them.

I think there is this institutional—what is the equivalent of institutional racism—institutional death-ism. Somehow the institution is operating on such a level that people are all going to die and then we do not have to worry about it. Then we can forget the studies anyway.

I appreciate you giving us this information. It is very, very disheartening. It reinforces my sense that we should just grant all these claims right now because they will never finish the study.

If they cannot find addresses, what more data do we need that they are incapable of doing this? It is ridiculous—these are human

beings. It is people. We are talking about people, who are suffering, and we cannot find addresses?

I thank you for your testimony. You taught us a lot. I think you showed us that there is a deeper problem than traditional committees and bureaucracies can deal with.

We will start with panel two. Rick Weidman is the Executive Director for Policy and Government Affairs of the Vietnam Veterans of America. Joseph Wilson is the Deputy Director of the Veterans Affairs and Rehabilitation Commission of the American Legion. Commander John Wells is the Cofounder and Trustee of the Veterans Association of Sailors of the Vietnam War. John Paul Rossie is the Executive Director of the Blue Water Navy Vietnam Veterans Association, and Dr. Vivianne Wersel is the Chair of the Government Relations Committee of the Gold Star Wives of America.

We thank you all for being here. We will recognize you for a 5-minute oral summary and your written testimony will be a part of the record.

Mr. Weidman, I have used your name a lot today, but welcome and thank you for all you do for our Vietnam veterans.

STATEMENTS OF RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA; JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; COMMANDER JOHN B. WELLS, USN (RET.), COFOUNDER AND TRUSTEE, VETERANS ASSOCIATION OF SAILORS OF THE VIETNAM WAR; JOHN PAUL ROSSIE, EXECUTIVE DIRECTOR, BLUE WATER NAVY VIETNAM VETERANS ASSOCIATION; AND VIVIANNE CISNEROS WERSEL, AU.D., CHAIR, GOVERNMENT RELATIONS COMMITTEE, GOLD STAR WIVES OF AMERICA, INC.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Thank you very much, Mr. Chairman, for holding this hearing and continuing to exercise leadership on this issue.

The law actually was not passed as mentioned earlier this morning in 2002. It was passed in the year 2000 as one of the last acts in that Congress that passed. It was originally due to the Congress on September 30th, 2004 and it was later amended and extended to September 30th, 2005.

There is a book that is still a very good book, although somewhat outdated now, by a fellow by the name of Fred Wilcox published by Cornell University Press. That was published in 1980. And the title of the book was, "Waiting For An Army To Die." And I said to Fred, Fred, this is a great book, but this is a little histrionic, the title of the book.

He had it right, he had it right 30 years ago that indeed you can argue that this is what the actuarial folks are doing at the Office of Management and Budget, which is waiting for an army to die. If you delay, delay, delay long enough, that will happen.

And one can almost come to no other conclusion. There is, of course, a saying in Washington that never attribute to malice that which can be explained by rank, gross incompetence.

But we do not think that the Office of Research and Development are incompetent. We think it is willful ignorance, that Mr. Hall had it right. They have refused to do Agent Orange research and they have refused to obey the law and meet the Congress' guideline that said they wanted the replication of the National Vietnam Veterans Readjustment Study in order to make it a longitudinal study and essentially serve as a robust morbidity and mortality study of Vietnam in-country vets versus Vietnam era vets versus nonveteran peers.

There is no other way to explain why they have delayed. It is the only group that we have, that is a statistically valid random sample where we have a beginning point 20 years ago, actually, more than 20 years ago now, and it should not take an additional 4 years in order to get this study done.

Much of the preliminary work was already done by Research Triangle Institute (RTI). VA continues to try and demonize RTI. And, in fact, if you read the Inspector General report, they do not demonize RTI, although they said they bought laptop computers out of sequence, but, in fact, it was VA who screwed up the contract. They did not write it properly. They did not write it with deliverables and due dates and timelines and milestones according to the Federal Acquisition Regulations that affect VA contracting.

So it was really VA messed it up and then tried to blame somebody else and then still did not want the information. And for a long time, we were puzzled. Why in the world would you not want this information when we know it is so important and everybody who is an expert in post-traumatic stress disorder and in the clinical field from National Center for PTSD to both APAs to all of the medical schools say this is vital information to know what is the chronicity of PTSD and how does it impact on us both in terms of neuropsychiatric health and how does it affect psychosocial readjustment and how does it affect physiological health.

And the only conclusion that we could come to is they did not want a robust mortality and morbidity study, which every single IOM panel since 1998 has said that is the only thing they lacked in order to do their work properly when it comes under the Agent Orange Act of 1991 is that they did not have a robust mortality and morbidity study of Vietnam veterans and recommended that VA do it and twice in the past decade have recommended specifically that they complete the National Vietnam Veterans Longitudinal Study and VA continues to not do it. At that point, it becomes willful flouting of the law.

In the private sector, if the Board of Directors instructed somebody to take on a project and get it done and they do not do it properly after 9 years and then they finally say, okay, we are going to do it and give it back to exactly the same people in charge of that part of the corporation, they would not do it. That person would be down the road and they would bring in somebody who wanted to do the job.

The purpose of the VA is not generalized health care. It is veterans' health care designed to meet the wounds, maladies and injuries, illness and conditions that stem from military service is the primary purpose. And it serves other purposes, too, but that is the primary purpose. That is what the American taxpayer pays for and

we are not getting it as long as you do not have the proper research.

So the first is obey the law, heed the will of the Congress, get the NVVLS done. We believe you can do it in 3 years, possibly even less, but I would certainly not challenge Dr. Marmar's clinical credentials on that.

But a lot of it is you could have conceived a baby. When the Secretary first instructed the Veterans Health Administration (VHA) to move ahead, it was August of last year. That is 9 months ago. That is 9 months ago and publicly announced it 8 months ago. A child could have been born in that period of time and they still have not put out a source that is sought.

This is just outrageous. You know they are bright people, so what do you attribute it to? Got me. I think it is a failure on many fronts.

And if I could just—I know I am over time, Mr. Chairman, but hopefully you will come back to the issue of Agent Orange because I did want to address that despite the colleagues here next to me.

I thank you very much for the opportunity, and I thank this Committee for the incredible leadership that you have exercised in helping us convince Secretary Shinseki to finally move ahead and get this study done. Thank you.

[The prepared statement of Mr. Weidman appears on p. 65.]

The CHAIRMAN. Thank you.

Please, Mr. Wilson?

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Mr. Chairman and Members of the Committee, thank you for this opportunity to present the American Legion's views on the National Vietnam Veterans Longitudinal Study and illnesses associated with exposure to Agent Orange.

And due to time constraints, I will limit my testimony to a brief chronological synopsis of the subject matter, which is discussed in its entirety and already on record. If I see that I am reaching that time, I will jump down to the American Legion and what the American Legion urges Congress to do.

In September 2009, VA announced plans to restart the follow-up to the 1984 National Vietnam Veterans Readjustment Study known as the NVVLS.

In addition, the new study will supplement research already in progress at the VA to include studies on post-traumatic stress disorder and the health of women Vietnam veterans.

One of the top priorities of the American Legion is to continue to assure that long overdue major epidemiological studies of Vietnam veterans who were exposed to the herbicide Agent Orange are carried out effectively.

Shortly after the end of the Vietnam War, Congress held hearings on the need for such epidemiological studies. The Veterans Health Program Extension and Improvement Act of 1979, Public Law 96-151, directed VA to conduct a study of long-term adverse health effects in veterans who served in Vietnam as a result of exposure to herbicides. The American Legion supported Public Law 96-151.

The Institute of Medicine or IOM has a report titled, "Characterizing the Exposure of Veterans to Agent Orange and Other Herbicides Used in Vietnam," which is based on research conducted by a Columbia University team and directed by principal investigator, Dr. Jeanne Stellman. The team had developed a contemporary method for characterizing exposure to herbicides in Vietnam. The American Legion is proud to have collaborated in this effort and endorses this IOM report.

There is a matter of children of Vietnam veterans and illness like type 2 diabetes. In 2001, VA added type 2 diabetes to the list of presumptive diseases associated with exposure to herbicides in Vietnam. It is the American Legion's contention that more conclusive research be conducted to determine if the effects of exposure to herbicides in Vietnam affected the offspring of those who served.

In 2003, the American Legion supported and endorsed the expansion of spina bifida benefits and set forth in H.R. 533 to a person suffering from spina bifida who is a natural child regardless of age or marital status of a parent who performed qualifying herbicide risk service provided that the individual was conceived after such service.

According to VA, spina bifida is the most frequently occurring, permanently disabling birth defect affecting approximately one of every 1,000 newborns in the U.S. The American Legion urges Congress to amend title 38, chapter 18, to provide entitlement to spina bifida benefits for the child or children of any veteran exposed to a Vietnam era herbicide agent such as Agent Orange in any location including those outside of Vietnam where herbicides were tested, sprayed, or stored.

Children of women Vietnam veterans. Under Public Law 106-419, the Veterans Benefits and Health care Improvement Act of 2000, VA also identified birth defects of children of women Vietnam veterans. The American Legion supported the above piece of legislation and urges Congress to include research involving women veterans who served in Vietnam to include in country and other locations and were exposed to herbicides, children of both men and women veterans who served in Vietnam to include in country and other locations and were exposed to herbicides.

The Institute of Medicine in update 2008 specified, well, stated that the evidence it reviewed makes the current definition of Vietnam service for the purpose of presumption of exposure to Agent Orange, which limits it to those who actually set foot on land in Vietnam seem inappropriate. The American Legion submits that not only does the most recent IOM report fully support the extension of presumption of Agent Orange exposure to Blue Water Navy veterans, it provides scientific justification to current pending legislation in Congress that seeks to correct this grave injustice faced by Blue Water Navy veterans.

In December 2009, IOM created a VA sponsored committee to further explore the Blue Water Navy exposure issue. The duration of this project is to last 18 months. The American Legion looks forward to the completion of this project.

The American Legion urges Congressional oversight to assure that additional information identifying involved personnel or units for the locations already known by VA as released by DoD as well

as all relevant information pertaining to other locations that have yet to be identified. Locating this information and providing it to VA must be a national priority.

The American Legion believes the new study facilitators should take heed of the circumstances prompting the abrupt halt of the 2001 NVVLS study. The American Legion urges Congress to insist on the assessment and review with all pertinent parties of all VA sponsored and IOM studies to fulfill the most recent charge by VA to ensure no evidence and information is lacking. To prevent that which occurred with the incomplete 2001 NVVLS study, the American Legion encourages proper Congressional oversight as well as continuous inclusion of stakeholders such as veteran service organizations.

Since 1990, when the American Legion brought a suit against the U.S. Government for failure to carry out its Congressionally mandated Agent Orange study, the American Legion remains steadfast in its belief that such studies are needed.

The American Legion firmly believes Congress should exercise Congressional oversight to make sure these studies it has mandated are carried out.

We also urge timely disclosure of ongoing studies by IOM through veterans and Agent Orange update publications promptly every 2 years as directed by Public Law 107-103, Veterans Education and Benefits Expansion Act of 2001.

Mr. Chairman and Members of the Committee, this concludes my testimony. Thank you.

[The prepared statement of Mr. Wilson appears on p. 68.]

The CHAIRMAN. Thank you.

Commander Wells.

STATEMENT OF COMMANDER JOHN B. WELLS, USN (RET.)

Commander WELLS. Thank you.

I learned how to work the microphone there. My name is John Wells. I am a retired Navy Commander. I am also representing the Veterans Association of Sailors of the Vietnam War.

I am an old steam engineer. I have been on a lot of the types of ships that served during the Vietnam War, although I did not personally serve. I am also an attorney. I think that makes me a dangerous combination. I know the VA seems to think so. My actual qualifications are in the written testimony, so I am not going to reiterate them here.

What I do want to do is talk about why we need to cover the Blue Water veterans, why H.R. 2254 needs to go forward. And, you know, I think it is hard for us to go now and test the waters. The Agent Orange dioxin is gone. It is no longer there. So we cannot come up with any kind of direct evidence, but we can certainly come up with circumstantial evidence. As an attorney, I can tell you there are a lot of folks in prison right now and rightfully so based on circumstantial evidence.

What can we show, what can we prove? One of the things that we can show, as the Chairman said, we do not need any more studies. I went and testified before the Institute of Medicine's new committee on Monday. Bright, intelligent folks, wonderful people, really interested, but the studies have already been done not by the

United States Department of Veterans Affairs but by the Australian Department of Veterans Affairs.

The University of Queensland back in the late 1990s got together with the Australian Department of Veterans Affairs who were saying, hey, we have more Navy veterans dying of Agent Orange cancers than we do land veterans. Why? Well, they went out, contracted with the Queensland folks. They went out and found out why. Because as the Agent Orange rolled out to sea—now, somebody I am sure from the VA will tell you it never rolls out to sea. Folks, it is oil based. I live in Louisiana. Come down to where I live. You will see what happens to oil going on the water. Okay?

As it goes out to sea or it is blown out to sea, people will say, hey, that is heavier than air, it is going to fall. Well, so is dust. And my wife tells me my office is very dusty and it blows around all the time. Okay? If you have ever sprayed fly spray, you know what happens if you spray it into the wind. The stuff does get blown out to sea and we have plenty of anecdotal evidence to prove that. And common sense will tell you that. It went into the ocean. It went into the South China Sea.

It was then brought in by the ships' distiller plants as they converted their water from saltwater to potable drinking water and unknown to anybody at the time, it went straight through the water distribution system and people drank that water. That is the methodology and a very important part of circumstantial evidence.

But we also know from the Australian study, and the Australians track all their veterans. I mean, I heard somebody say, oh, we do not know where our veterans are. I am like come on, you could have put that on the Census. I mean, come on, VA, this is not hard. They track them all. They track them individually. They know where they live. They know what kind of diseases they have. That is how this whole thing got started.

And we know that there is a 19 percent mortality rate due to cancer, 19 percent above the average based on the Australian mortality studies, which we should have been doing all along.

Based on their cancer instance studies, we also found out, and this is the smoking gun or the corpus delicti, what type of cancers are being caused by Navy veterans and guess what? There are all types of things caused by our oral ingestion, by head, neck, throat, larynx, esophagus, stomach, colon, gastrointestinal system. That is the type of cancers that are being developed by the Australians.

Now, I can tell you. Australians are built just like Americans. I know. I am married to one. Okay? And there is no difference. Why do we need another study? Why do we study this to death? Why can't we use what the Australians have done?

Nobody at the Department of Veterans Affairs has ever called Dr. Keith Horsley at the Australian Department of Veterans Affairs. He said he has never gotten a call. The University of Queensland folks, they have never gotten a call. I have their phone numbers. If anybody wants them, I will be more than happy to give them to them. I gave them to the IOM. Hopefully they will call.

Folks, this is not hard. The studies exist. We cannot keep studying this to death.

Everybody talked about, you know, the fine job the Vietnam vet, Duane Johnson did, you know, on the Times Square incident. He

saw something and he took action. What would have happened if the VA had observed that SUV sitting there? People would have died. That is what would have happened. And guess what? People are dying now. People are dying now because the VA is not taking the action. They are not going out with a bang or a blast of a bomb. They are going out with a torturous cancer in a painful way as their bodies are being eaten away while we study, study, study.

You know, I dealt with the Australians. I am over time. I am sorry, or almost over time. I am sorry. But I have dealt with the Australians. They are a pleasure to talk to. They answer the mail. They answer the e-mail. They answer the phone call. They will give you their home phone. They really care.

If you talk to the Australian vets, they talk about their Australian VA with respect, with gratitude. Our folks say, hey, they just give you a second chance to die for your country and often refer to them by names such as the Department of Veterans Abuse.

I am proud of my country. I served 22 years as a Navy officer. I am proud of being a Navy officer. I am proud of being a military person. I am proud of our government. I am proud of our President. I am proud of our Congress. I am proud of our Supreme Court. I wish I could say I was proud of my VA, but I cannot.

I am over time. I thank you for the opportunity to talk to you today.

[The prepared statement of Commander Wells appears on p. 72.]

The CHAIRMAN. Thank you, sir.

Mr. Rossie.

STATEMENT OF JOHN PAUL ROSSIE

Mr. ROSSIE. Thank you.

My name is John Paul Rossie. I am a Navy veteran of the Vietnam War. I am currently the Founder and Executive Director of the Blue Water Navy Vietnam Veterans Association. That is based in Littleton, Colorado.

For the record, I would like to state that Blue Water Navy refers to Coast Guard, Navy, Fleet Marines, and other servicemen that were offshore Vietnam and their widows and their children.

I submitted my written testimony for the public record. It deals specifically with the veterans who did not have their boots on the ground and who are addressed by H.R. 2254. I respectfully request that each of you personally review this document. It contains facts and it offers solutions.

It discusses how the Department of Veterans Affairs has been presenting this Committee with contrived numbers relative to H.R. 2254. It very clearly shows you that you have been misled about the head count of the Vietnam veterans and about the cost of treating the veterans who are victims of chemical warfare. And this is truth. We need to call it like it is. It was designed to kill jungle foliage. It inadvertently killed human beings.

As I find myself seated here surrounded by all of you, because I was invited here today, I have mixed emotions. I am honored to be associated with the group, the Blue Water Navy Association, that has earned a seat at this table.

I am mortified to have to sit before a Committee and plead for the health benefits of American veterans of the Vietnam War that are desperately needed. We should have never gotten to this point.

Mostly I am stunned to realize that I am pleading before individuals who have already promised to help America's Vietnam veterans. If your promises had not been so convincing, you would not be seated on your side of the table because the promises you make are why we elect you to fill those seats.

I am proud to say I am here because I want to help restructure a Department of Veterans Assistance, but apparently that cannot be done without the help of a strong legislative body such as a Committees like this which I hope would be renamed the Committee for Veterans Assistance.

Before I roll up my sleeves and get to work, I would like to clear up some heavier issues. I am not at all comfortable when prominent individuals and august bodies such as this make promises that they do not keep and that people actually die because of it.

I am appalled when I have to witness the warriors of the greatest generation, our parents, having to bury their children who did not die of natural causes. They are dying because companies like Dow and Monsanto are being protected and insulated by my government.

Our parents are burying their own children who have been deprived of a long, prosperous life, cut short by an average of 13 years and racked by many years of pain and physical disability. And I am disheartened to see that this trend continues with our own children serving in the Middle East.

Many things have to change and I am here to offer my help. This coming year, we will see the highest death toll of Vietnam veterans to date. Every day the Congress delays in getting the veterans their basic medical benefits, another 300 or more veterans from the Vietnam War will die because of that. You cannot stop them from dying, but you can ensure that their final years, months, weeks provide them and their families basic human dignity.

We also suspect there may be a high suicide rate among Vietnam veterans who more likely than not are going to see H.R. 2254 and S. 1939 delayed by this Congress. And they will be facing their greatest adversary, the Department of Veterans Affairs, as is a phrase used by Congressman Filner.

So I end with a question. What can I do to help you make H.R. 2254 and S. 1939 law of the land? Thank you.

[The prepared statement of Mr. Rossie appears on p. 79.]

The CHAIRMAN. Thank you, sir.

Dr. Wersel.

STATEMENT OF VIVIANNE CISNEROS WERSEL, AU.D.

Dr. WERSEL. Mr. Chairman and Members of the Committee, I am pleased to be here today on behalf of Gold Star Wives. I am Vivianne Wersel, the widow of Lieutenant Colonel Rich Wersel, United States Marine Corps, who died suddenly a week after returning from the second tour of duty in Iraq. I am also the daughter of Colonel Phil Cisneros, United States Marine Corps retired, served three tours in Vietnam.

We are heartened by the restarting of the National Vietnam Veterans Longitudinal Study as it is very clear that our knowledge is not yet complete on the long-term health consequences of those who served in Vietnam.

However, we cannot forget the importance of communication to the impacted community including surviving spouses and their children.

Therefore, it is important to further investigate the results of the effects of the deadly toxins used in Vietnam as well as to identify the servicemembers, their spouses, and surviving spouses. Not everyone has a connection with the military and the VA.

We have concerns for the veterans and their survivors who were never in the VA system but became ill and died. Many veterans may have died years ago under conditions caused by Agent Orange. The VA must take a lead in outreach to these servicemembers and survivors.

A common theme that our members encounter is a lack of information, the lack of the government reaching out to them to alert them of changes in benefits and compensation that they may be eligible to receive. Many were never informed of benefits initially and many still are not aware of their benefits.

So while it is wonderful for the scientific community to gain these valuable insights, the next crucial step is to assure that those who have been harmed as a result of the chemicals will be identified. Therefore, the VA outreach to survivors must be drastically improved.

My uncle served and died of amyotrophic lateral sclerosis (ALS). He served his country in the Marine Corps. My aunt was not married to him during his military service and was unaware of the changes of the VA policy to include ALS as a presumptive illness. This benefit made a difference to her quality of life, yet she never would have known it if I had not made a point to share the information with her. She was grateful of the VA Respite Program during his final months and is concerned that other families are unaware of the significant benefit.

We are certain that there are many other surviving spouses who have yet to be identified as beneficiaries as was my Aunt Sandy. We, as a grateful Nation, have the ethical role to reach out to better identify those veterans and survivors who qualify for compensation.

A widow in Florida has an adult son with spina bifida. Her son is relatively independent and, yet, still needs care. Since the loss of her husband, the widow now bears the full burden of caring for her adult son.

For many years, caregivers provided for their spouses who were less than 100-percent disabled and these widows were not eligible for Dependency and Indemnity Compensation when their spouses died. The caregiver's quality of life was compromised as well as their own health. Many spent their life savings on medical expenses. Spouses were forced to give up careers because their disabled husbands needed ongoing care.

We do not want new members in our organization because the requirement for entry is loss of a loved one, but we are protective of those who eventually will join us as well as for those surviving

spouses who suffered right along with the veteran. They need to be given some peace of mind about why life was so radically different for so long after their spouse returned from Vietnam, whether it was from PTSD or burying a child with a neural tube defect or sadder yet, left barren.

Results of the present longitudinal study may reveal new presumptive illnesses that not only affect the servicemember but many generations thereafter. Service to this Nation deserves life-long respect and care, certainly to the veteran, but to the veteran's family as well even when the veteran is no longer alive.

Simply stated by one of our members, I just pray that no one else has to go through what Les went through, a very tortured, painful, long, anguished death. After his death, I was burdened with medical bills, exhaustion, and ruined career that I am still trying to repair.

The Vietnam veteran did battle for our country and now has to battle with the VA and the VA bureaucracy rules to obtain the benefits he deserves and has more than earned. In many instances, the surviving spouse must continue to fight for the benefits the veteran earned.

It is our responsibility as a Nation to honor these veterans and their survivors. We hope that the restart of the study will continue to reveal data and information crucial to the optimal well-being of our servicemembers and their families. It is imperative that a more aggressive outreach is implemented to identify veterans, spouses, and survivors concerning any new presumptive illnesses developed as a result of the study.

Thank you for the opportunity to testify and I will answer any questions you may have. Thank you.

[The prepared statement of Dr. Wersel appears on p. 85.]

The CHAIRMAN. Thank you, Dr. Wersel.

And thank all of you.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

I guess, Commander Wells or Mr. Weidman, I appreciate well the whole panel first of all for coming here this morning. This has definitely been very informative.

And you mentioned the Australian study and I do know that the Canadians actually have given benefits for the soldiers in Canada that served, you know, had time at Gagetown.

I guess my question is, you mentioned the Australian study, did the Canadians do a study as well or is it just Australia that had a comprehensive study?

Commander WELLS. I do not know, sir, if the Canadians did a study. I think they may have relied on the Australian studies, which were pretty comprehensive.

And by the way, I failed to mention the Australians have been granting benefits to their Blue Water Navy veterans for several years now. So, you know, the Australians and the New Zealanders, as well as the Canadians, have been giving the benefits that we are asking you to provide by H.R. 2254.

Mr. WEIDMAN. There were a couple of small studies of the veterans in Gagetown done by the Ministry of Health in Canada, but they also relied on the international science, which is incidentally

what we have had to do since we do not fund any Agent Orange related research.

Currently VA lists three things. You go to the VA Web site and punch in on the research Agent Orange research funded by VA. They bring up three things.

One is the women's study as if it is ongoing. And, in fact, they have not completed the Institutional Review Board (IRB) process on that after 9 months. Once again, these ladies could have all had a baby in that time.

And, number two, they list a study by Dr. Han Kahn who works 2 days a week, he is semi-retired from VA, not funded by the Office of Research and Development, by the way, but funded by Public Health and Environmental Hazards. And Dr. Kahn is doing two studies.

One is that one, this one which is looking at the Agent Orange registry to discover how many of those people have PTSD. We have a hard time coming to the conclusion or agreeing with the conclusion that it is Agent Orange research. And the second one is a meta-analysis of some earlier work and looking at death rates.

We have a lot of respect for Dr. Kahn, but this is a paltry effort given the amount of energy and the number of veterans affected and the energy that you as Chair and your colleagues on the Subcommittee on Health and the full Committee on both sides of the aisle have put into this issue of trying to discern the truth. This is the best that VA can come up with given the fact that they have a research budget of \$540 million a year. We have a hard time with that.

So for the second year in a row, VVA did not support VA research and development week, which was last week. It is not because we do not support medical research. We are the only veteran service organization that is a member of Research America, which is a broad coalition of folks who support increased medical research by funds through the National Institutes of Health, through the Center for Disease Control and Prevention, through the Agency for Health care Research and Quality, et cetera.

So it is not that. It is that they are not doing their segment of the job, which is to research into the wounds, maladies, injuries, illnesses, and conditions that emanate from military service.

Dow Chemical is not going to fund it. VA should be funding it.

Mr. MICHAUD. My second question is, as you heard, Secretary Shinseki is moving forward on this and it is good to see that he is moving forward, but a lot of times, even if a Secretary does say something and it is directed down below, they could delay it for those who might not want the study to go forward.

Clearly there is a change in the top Administration. The people who are supposed to be dealing with this longitudinal study within the bows of the VA, are they pretty much the same ones that have been there before and do you feel that that is where the problem is going to come even if they have a lot of push from the Secretary himself?

Mr. WEIDMAN. Congressman, I came dangerously close to being *ad hominem* today and I do not mean to be. It is not appropriate. It is not who does it. It is what gets done by an agency.

The Secretary is ultimately responsible, but our view on him is he is extraordinary. And he has really been a breath of fresh air. He made the decision to move ahead and instructed VHA last August and publicly announced it on September 15th. And we kept asking what is happening, what is happening, what is happening by e-mail, not by formal exchange of correspondence.

And in January, we pushed hard enough, said, okay, you keep saying that you are working on it, who is working on it. In which case, they turned to the General Counsel and the Deputy General Counsel, I get a message or a missive from him saying you are trying to interfere with a procurement process. No, I am not. I am not going to bid on the damn contract. What the hell is wrong with you? We just want to make sure it is done right.

We shared all of that e-mail correspondence with the staff of the Subcommittee on Health on both sides of the aisle, and so it is documented, and had conversations with the Chief of Staff and with the Secretary as recently as breakfast this morning. And he was somewhat surprised to find out that they were not funding anything having to do with Agent Orange and that the NVVLS still there was no publicly visible action on it. Maybe there is some behind the scenes that they refused to share with us.

But from our point of view, there are certain things on procurements that you have to keep confidential until it is listed in the *Federal Register*. But the general strategy, you do not have to go silent on. You do not have to put up a Wall of Omerta, if you will, towards either the constituents and representatives or certainly not towards the Congress.

The CHAIRMAN. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Let me just ask each of you yes or no. I mentioned earlier that I like the idea of an interim report from the VA on the longitudinal study.

Do you agree? Just go across.

Mr. WEIDMAN. Yes, sir.

Mr. WILSON. Yes.

Commander WELLS. Yes, sir.

Mr. ROSSIE. I think the answer is yes, but I think they have enough to move on right now.

Dr. WERSEL. Yes.

Mr. STEARNS. Okay. Mr. Weidman, do you think the experiences of servicemembers in Iraq and Afghanistan are similar enough to benefit the findings of the longitudinal study?

Mr. WEIDMAN. It is going to inform us a lot about the course of the disease over or the medical condition over a lifetime, Mr. Chairman, and that is going to for planning purposes for this Committee and for the Appropriations Committee as well as for VA should inform what kinds of things you are doing now.

Example is the Capital Asset Realignment for Enhanced Services formula. If you know that people are going to have X, Y, and Z conditions, you need to be planning for that and the facilities that you are building today that will still be in use 20 years from now. So the answer is, yes, it will be valuable.

Mr. STEARNS. So you are saying you feel very strongly that the experiences in both Iraq and Afghanistan are similar?

Mr. WEIDMAN. In terms of combat? Combat is combat.

Mr. STEARNS. No. But I mean in terms of environment and the effects on this longitudinal study, dealing with a longitudinal study. I am not talking about combat, but I am just saying the environment.

I mean, I guess maybe the question could be re-phrased. Are there differences between the two that would have to be nuanced in the study so that we would be aware of what the benefits would be for the veterans?

Mr. WEIDMAN. Well, the answer to that question is this, is that we should be doing epidemiological studies of a robust size on every generation of veterans. The Australians have completed three complete epidemiological studies on their Vietnam veterans and are running epidemiological studies on their soldiers who have served in Iraq and are today serving in Afghanistan. That is what we need to be doing and track people over the course of a lifetime.

Why do you do that? You do that so that the anomalies start to show up which in and of themselves would be enough in many cases for the Secretary to move to service-connect and make sure that they are getting medical treatment and benefits where deserved and but also should inform where you invest your research dollars.

If your primary purpose is the wounds, maladies, injuries, and conditions that stem from military service and it is, it is not a generalized medical system, then that should be informed by those epidemiological studies.

There is finally some movement, at least at the top level of VA, to start to address the need for an overall epidemiological study.

Mr. STEARNS. I assume there is no other study besides the Australian study? I mean, the Canadians. There is no other—

Commander WELLS. The only studies that we know of as far as the Blue Water Agent Orange are the Australian studies. The United States VA has not done. I am not aware of any Canadian.

I can tell you the Australian study has been peer reviewed. It was presented several places, Korea and a few other places, although VA put in the *Federal Register* it was not peer reviewed, but, in fact, it was and that information is in the prepared text.

The doctor, Steven Hawthorne, was asked by the Institute of Medicine, he is from the University of North Dakota, to review the Australian study and he came back and validated its results. So as far as I know, that is the extent of the research.

Mr. WEIDMAN. The key question perhaps, Mr. Stearns, was asked at the IOM Committee meeting on Monday afternoon when one of the scientists, after going back and forth on this, whether VA had the standing, said that they had severe doubts about the methodology and validity of the Australian study.

She asked the key question which is have you funded an effort to replicate this study to see if you have the same results. That is what makes science science is if you replicate it and you do not get those results, then you have got a real problem.

VA has the money, but they have never in all this period of time, I think it is 8 years since the Australian study came out, 9 years, have not tried to replicate that study. They shoot it down, discount it, but do not try and replicate it.

Mr. STEARNS. I am just going to conclude, Mr. Chairman, and ask each of them a question.

This question is a little subjective. You do not even have to answer it. But based upon the history here, how satisfied are you with the VA's recently announced plan to complete the study as required by law? Do you believe they will meet the established timeline of 2014?

Do you feel confident that will happen, Mr. Weidman?

Mr. WEIDMAN. I believe that Secretary Shinseki is serious as a heartbeat about it.

Mr. STEARNS. So under his leadership, you think it will occur?

Mr. WEIDMAN. Under his leadership, it will occur despite road blocks that may be thrown in the way.

Mr. STEARNS. Mr. Wilson.

Mr. WILSON. Well, while excited about the 2009 announcement, we are still a little puzzled about—

Mr. STEARNS. So your answer would be no? I am just looking for yes or no here. Maybe?

Mr. WILSON. Yes.

Mr. STEARNS. Okay. Mr. Wells.

Commander WELLS. Based on history, I would have to say I would be very surprised if they did.

Mr. STEARNS. There is a no. Okay.

Mr. Rossie.

Mr. ROSSIE. Historically I would suspect that it would be late.

Mr. STEARNS. No. Okay.

Dr. WERSEL. I agree. I think it would be late. I think they might just hope we forget about it.

Mr. STEARNS. Okay. Mr. Chairman, we have the veterans coming up in the next panel and so they have their work cut out for them because they have the group here, almost the majority of them, more than the majority think that they will not meet the deadline.

Thank you.

The CHAIRMAN. Thank you, Mr. Stearns.

Again, we thank all of you for testifying and making us all aware, or reminding us, that with all the words about studies, there are people here and we have to take care of them. I thank you all.

Mr. Weidman, I think it is within the gift laws limitation if you can get me Wilcox's book, that would be great. All right? Thank you very much.

Thank you all.

The third panel joining us this afternoon is Dr. Joel Kupersmith, the Chief Research and Development Officer of the Veterans Health Administration, accompanied by Dr. Victoria Cassano, Director of Radiation and Physical Exposures and the Acting Director of the Environmental Agents Service of the Veterans Health Administration.

Thank you for being here. Dr. Kupersmith, you may proceed.

STATEMENT OF JOEL KUPERSMITH, M.D., CHIEF RESEARCH AND DEVELOPMENT OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY VICTORIA ANNE CASSANO, M.D., MPH, DIRECTOR, RADIATION AND PHYSICAL EXPOSURES, AND ACTING DIRECTOR, ENVIRONMENTAL AGENTS SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. KUPERSMITH. Thank you.

Mr. Chairman, Ranking Member, and Members of the Committee, thank you for the opportunity to appear today to discuss our progress in conducting the National Vietnam Veterans Longitudinal Study and the illnesses associated with exposure to Agent Orange.

I am accompanied today by Dr. Victoria Cassano from our Office of Public Health and Environmental Hazards.

In 1983, the Congress mandated that VA conduct a study on post-war psychological problems among Vietnam veterans. VA contracted with an external entity, the Research Triangle Institute, to conduct the National Vietnam Veterans Readjustment Study.

The study completed in 1988 provided an extensive report of disabilities including post-traumatic stress disorder in Vietnam era veterans and is considered to be a landmark study of post-traumatic stress disorder and its consequence in Vietnam veterans.

In 2000, Congress passed and the President signed the Veterans Benefit and Health care Improvement Act, which became Public Law 106-419. Section 212 of this legislation directed VA to contract for a follow-up study of Vietnam veterans in the original 1988 NVVRS.

In 2001, individuals then at the VA entered into a contract with the same contractor for NVVLS. However, delays, escalating costs, and concerns about contracting practices prompted suspension of the study and cancellation of the contract before data collection began.

An Office of the Inspector General audit report confirmed these concerns.

Following these events, VA initiated a broad portfolio of scientifically rigorous studies dedicated to addressing the needs of the Vietnam veteran population and offered two of these as alternatives to restarting the NVVLS.

In September 2009, the Secretary of Veterans Affairs announced that the Agency planned to award a contract to an external entity to conduct NVVLS. VA has reinstituted the process to contract for completion of NVVLS paying close attention to prior OIG recommendation and the intent of Public Law 106-419.

In September 2009, the Office of Research and Development took over the study. We convened a scientific panel and other experts as part of an integrated project team to develop requirements for NVVLS. The scientific panel consisted of subject matter experts from within and outside the Department, a number of whom were involved in the original NVVRS study.

This panel identified several challenges to reopening NVVLS, which are detailed in my written statement.

As part of reopening NVVLS, the integrated project team developed a performance work statement and acquisition package during 2009.

In early March 2010, this group forwarded the package to the VA Contract Review Board. Once the acquisition package has been approved, VA will solicit bids and evaluate proposals.

We expect this will be completed this summer. VA will then award the contract and begin the study in early fall. The integrated project team has determined milestones for the study and the contracting officer will use performance metrics to monitor progress to avoid previous problems.

Between 2011 and 2013, the awarded contractor will obtain Institutional Review Board, which is part of every study done by everyone inside and outside the VA, and Office of Management and Budget approvals for the project and initiate the study under VA monitoring.

By 2014, the data should be available for analysis and we anticipate the results will be available shortly thereafter for publication in the Scientific Journal.

VA is committed to the success of the NVVLS and will continue to keep Congress apprised of any significant developments. I believe it has already made progress reports on it.

In addition to its research portfolio for Vietnam veterans, VA has a number of health care programs specifically designed for this population. VA established the Agent Orange Registry to track the special health concerns of veterans who may have been exposed to Agent Orange during their military service.

VA also operates three War-Related Illness and Injury Centers that provide clinical expertise for veterans with deployment health concerns or difficult to diagnose illnesses.

VA is also in the process of updating the Veterans and Agent Orange Veterans Health Initiative, which will cover a range of issues including Agent Orange, infectious diseases, PTSD, other psychological outcomes and reproductive outcomes specific to the Vietnam War.

Earlier this year, the VA published a regulation to establish presumptions of service-connection between exposure to herbicides in Vietnam and Parkinson's disease, ischemic heart disease, and all B-cell leukemias. The new rule will bring the number of categories of illness presumed to be associated with herbicide exposure to 14 and significantly expand the current leukemia definition to include a much broader range of chronic B-cell leukemias beyond chronic lymphocytic leukemia previously recognized by VA.

VA has previously recognized a number of other illnesses as presumptively service-connected for exposure to herbicides during the Vietnam War.

Mr. Chairman, Vietnam veterans represent the largest proportion of veterans in terms of service area and VA will continue to deliver them the quality of health care and benefits they deserve.

I thank you again for your support for our work in this area and for the opportunity to appear for you today. I am now prepared to answer your questions. Thank you.

[The prepared statement of Dr. Kupersmith appears on p. 86.]

The CHAIRMAN. Dr. Kupersmith, we put the VA on the third panel so they could listen to the first two and then respond.

Dr. KUPERSMITH. Yes.

The CHAIRMAN. You have not said a word about the earlier testimony. You read your prepared statement——

Dr. KUPERSMITH. Well, I——

The CHAIRMAN [continuing]. Which basically said what I said.

All you do is confirm the fact that all you care about is process and not about people. Why don't you respond to some of the issues that were raised?

Dr. KUPERSMITH. Okay.

The CHAIRMAN. Why is this taking so long? In fact, tell me who should be fired because it has been taking this long and why are you not responding to the substance of the situation?

Dr. KUPERSMITH. Okay. Well, I am happy to answer the questions. And first of all, let us talk about the feasibility of the study. I think it was said that the reason that we had some questions about the feasibility was the ability to find the veterans. That is not true.

The feasibility and the numbers that we have depend on how many veterans are still alive, how many will consider——

The CHAIRMAN. Why do we need this? Are people not suffering from Agent Orange problems? Why don't you just treat them and give them the disability payments?

Dr. KUPERSMITH. Well, I——

The CHAIRMAN. Why are you going through all this stuff?

Dr. KUPERSMITH. Okay.

The CHAIRMAN. It is ridiculous to ask questions if you are going to give me the same explanation about the process.

Dr. KUPERSMITH. I do not think it is process, if I may say that. We will determine the number of veterans who can answer these questions. That is part of the study.

The CHAIRMAN. I could have told you Parkinson's was presumptive 20 years ago. Why did it take you this long to compensate the disease?

Dr. KUPERSMITH. Well, if you would like——

The CHAIRMAN. Or any of the other 13 or 20 diseases?

Dr. KUPERSMITH [continuing]. I represent research. If you would like, we have a representative from Veterans Benefits Administration (VBA) here, Mr. Sampsel, and if you wish, he can answer questions directed at those.

The CHAIRMAN. Okay, Mr. Sampsel, please come to the witness table. He does not look too happy about coming forward. What was the question that you referred for him to answer?

Dr. KUPERSMITH. Well, you have questions apparently about benefits. If you wish to ask them——

The CHAIRMAN. I am saying why are we not giving these veterans any benefits? Why are we putting them through this incredible bureaucratic maze where people die while fighting for benefits?

Mr. SAMPSEL. Mr. Chairman, my name is James Sampsel. I work for Compensation and Pension Service. I think it is——

The CHAIRMAN. You work for who? I am sorry.

Mr. SAMPSEL. Compensation and Pension Service, VA, VBA. We provide compensation. I have sympathy for Vietnam veterans also. I happen to be a Vietnam veteran.

The CHAIRMAN. Well, that is very nice of you. I appreciate that.

Mr. SAMPSEL. And I think it is easy to——

The CHAIRMAN. Sympathy is not what they are looking for. They are looking for treatment and compensation.

Mr. SAMPSEL. Well, I do not know that I can answer your questions.

The CHAIRMAN. That is what I thought.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Doctor, you mentioned that the VA is committed to the success of this longitudinal study.

Dr. KUPERSMITH. I am sorry. I could not understand what you said.

Mr. MICHAUD. You had mentioned that the VA is committed to the success of this study——

Dr. KUPERSMITH. Yes.

Mr. MICHAUD [continuing]. The longitudinal study. I guess my concern is we required that a long time ago. And the big concern that I have just only being on this Committee for a short 8 years, the Committee actually passed legislation that required the VA to pay the full cost of veterans' nursing home care for State Veterans Homes. The VA decided, through their rule-making process, to narrow what full cost meant.

Also in 2009, and I will get to my question, in 2008, we passed Mr. Moran's legislation that said the VA will establish five pilot programs within each Veterans Integrated Service Network (VISN), the total VISN. The VA was ready. They did not report back until March. They said they cannot implement that legislation. They needed changes.

We changed the law. Then VA was actually looking at narrowing the full VISN pilot program to certain regions within the VISN, which is contrary to what the law stated. Thank God that the VA is going to now do the full VISN.

My concern is that even when Congress and the President might pass legislation, those who are supposed to implement it is doing everything they can to implement it the way that they want it. And the fact that it has taken this study so long and we are still not getting anywhere is really concerning.

And according to the GAO report, VA confirmed that it would release the request for proposal in the spring of 2010 and it is already May 5th and the request for proposal has not yet been released.

You know, what is the cause of the delay and is the VA really moving forward and interested in getting the study done is my first question?

My second question is, why can you not use what Australia did? We heard a lot in the previous panels about Australia. Why can you not utilize that study? Is there something wrong with that that we cannot utilize it? And I would like you to answer those two questions.

Dr. KUPERSMITH. Okay. Thank you.

Yes. We are committed to do this study. We took this study over when the Secretary directed us to do it. The first part of it has been discussing all the aspects with a scientific panel. And as I said before, the scientific panel consists mainly of people who were involved in the NVVRS study, so they are very knowledgeable in this area. And I believe the advice they have given us is of the highest, highest quality.

The other part of the initial process has been to be meticulous about contracting. I mean, looking back to the first attempt at this, we read very carefully the Inspector General's report. There is a number of items of recommendation that they made about contracting and we are following every one of them.

We expect that the contract will be let, if that is the right term, very soon, this month, and it is in the very last phases. Contracting is, as you know in government, a difficult process, but it is being done.

Once that is done, you know, there will be bids and when the contract is awarded, we have assured this time around unlike last time that the contractor will have to have a plan, a research plan for this and will have to abide by performance measures and a number of other factors that were not done before following the OIG report.

The time we take now, I mean, certainly this has been delayed many years, the time we take now to assure meticulousness about contracting will be less time in the future if it is done incorrectly. So that has been our approach.

Now, as far as your other question, I think perhaps one of the other members can answer, address those.

Dr. CASSANO. Sir, could you please repeat the second question for me?

Mr. MICHAUD. You heard about the Australian study that went on. Why can we not use that? Is there something dramatically wrong with that study that we cannot utilize that?

Dr. CASSANO. Sir, I am well aware of the Australian study as are other individuals in my office. To go back a little bit, we were already in discussion with Institute of Medicine on doing a Blue Water Navy study before this last panel reported out. The small segment of that entire report that was given to the Blue Water Navy issue did not seem to us to be robust enough for the Secretary to be able to—for us to be able to make any recommendation to the Secretary.

We think the Australian study needs to be looked at. We also want to look at any other relevant information. Blue Water Navy means a lot of different things.

And just to reiterate boots on the ground, as you know, sir, it is not just boots on the ground. It is boots on the ground and those serving as riverines and in the inland waterways and the coastal ships.

We have very many Blue Water ships that are already and continue to be included in the Brown Water Navy cohort of ships, over 20, and we add more every week, every month almost. That is continually being updated.

The question becomes do you make this entire issue one that goes all the way out to Yankee Station, which is 100 miles offshore

or similar to where the Australian ships were operating, which was slightly different than where all of our Blue Navy ships were operating.

So I think it is in the best interest of all of us, of all Vietnam Veterans. And believe me, sir, I was in college at the time and if I were male, I probably would have been a Vietnam vet. I am a veteran. I am retired Navy. These were my friends and my colleagues that were over there. So it is not a matter of not being interested. It is a matter of trying to actually align the science with what we may empirically know and what we may anecdotally know.

But based on the laws that we are required to work with under the IOM process, we need scientifically significant——

The CHAIRMAN. Why did you reverse the policy toward the Blue Water Navy veterans? There was no new law. You have the authority to change it. Why don't you change it back?

Dr. CASSANO. Sir, I cannot speak to that. I can certainly find that for you.

The CHAIRMAN. Who can?

Dr. CASSANO. I will get that answer.

The CHAIRMAN. Can anybody? Apparently the Blue Water Navy was considered to be part of the cohort and then it changed. You are talking all about aligning the science with anecdotal and empirical knowledge. I want to know why this policy was changed and why you don't just change it back? You have the authority to do if you changed it from one to the other.

Dr. KUPERSMITH. I do not have the authority. I mean, so we will take that question and respond to it.

[The VA subsequently provided the information in the answer to Question #14 in the Post-Hearing Questions and Responses for the Record, which appears on p. 110.]

The CHAIRMAN. Thanks. Appreciate it.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Dr. Kupersmith, were you involved with the original longitudinal study back in 2003, 2004?

Dr. KUPERSMITH. No.

Mr. STEARNS. Were you involved with it subsequent to 2004? I mean, were you involved in 2005, 2006? Did you ever have any contact, any relationship with the program?

Dr. KUPERSMITH. Not with the study itself, but it was discussed while I was there, yes.

Mr. STEARNS. It was discussed?

Dr. KUPERSMITH. Yes.

Mr. STEARNS. So you were familiar with it; is that correct?

Dr. KUPERSMITH. Yes.

Mr. STEARNS. And were you familiar with the fact that they were not fulfilling the contract, that they——

Dr. KUPERSMITH. The contract?

Mr. STEARNS [continuing]. Had put out a contract? They found that the contract had malfeasance. And were you aware of the whole problem that occurred?

Dr. KUPERSMITH. Yes. I was made aware of the——

Mr. STEARNS. So you cannot——

Dr. KUPERSMITH [continuing]. Inspector General report, yes.

Mr. STEARNS. Okay. So my point is since you knew about it and were aware of it, then you want to make sure it does not happen again.

Dr. KUPERSMITH. Correct.

Mr. STEARNS. Okay. Do you agree with me that we should have an interim report on this——

Dr. KUPERSMITH. Yes.

Mr. STEARNS [continuing]. Before 2014?

Dr. KUPERSMITH. Yes. We have agreed to make those reports, yes.

Mr. STEARNS. Those reports plural or a report to Congress, this Committee, the full Committee?

Dr. KUPERSMITH. Well, I am sorry. My apologies. We have agreed to make interim reports, but obviously will make any report that you wish, certainly.

Mr. STEARNS. So you think you have no objection to doing an interim report to this Committee on how you are doing on the longitudinal study; is that correct?

Dr. KUPERSMITH. Yes.

Mr. STEARNS. Okay. I have a White Paper from your office that we received in March 2010, and it is entitled National Vietnam Veterans Longitudinal Study Narrative Summary of Activity October, December 2009, in which you outline your timeline.

Dr. KUPERSMITH. Yes.

Mr. STEARNS. It said here that you plan to submit the acquisition plan to the Office of Procurement and Logistics at the end of March 2010. Did you do that? Yes or no?

Dr. KUPERSMITH. Yes.

Mr. STEARNS. You go further on in this report, it says due to the longer than expected preparation of the scientific requirements and a potential change in contract support structure, the acquisition package is now expected to be released in April 2010.

So this paper disputes that you met the March 2010. In fact, it slipped to April 2010.

Dr. KUPERSMITH. Yes.

Mr. STEARNS. Are you incorrect?

Dr. KUPERSMITH. I am sorry. I——

Mr. STEARNS. When I initially asked you if the acquisition submission plan would be done by March 2010, you said yes. Then the next paragraph of your own White Paper says that you missed that deadline and the package is now expected to be released——

Dr. KUPERSMITH. Okay.

Mr. STEARNS [continuing]. April 2010.

Dr. KUPERSMITH. I am sorry. The dates I have are the acquisition package was forwarded to the contract office on March 23rd. A contract officer in VISN 6 was assigned on March 29th and that is where the package is now. We anticipate that the contract will be let out, as I said, imminently this month.

Mr. STEARNS. So was it let out in April 2010?

Dr. KUPERSMITH. No.

Mr. STEARNS. Okay. So you missed your deadline there.

Dr. KUPERSMITH. Okay.

Mr. STEARNS. Okay. That is my point.

Dr. KUPERSMITH. Okay. I am sorry.

Mr. STEARNS. My point is it appears from the get-go you as a person who knew about the problem have already recognized that you are not meeting your own timeline. Is that a correct statement?

Dr. KUPERSMITH. Well, yes. I mean——

Mr. STEARNS. Okay. Okay. Yes or no. That is all I am asking.

Dr. KUPERSMITH. Okay.

Mr. STEARNS. Okay. So the panel two before you almost in the majority said, no, the longitudinal study will not be met on time. So you can see why they are a little pessimistic because I just illustrated that you cannot even meet your own deadlines. And this here is your White Paper.

So I guess when can you tell us today that the acquisition package will be approved and will be sent to contractors for their solicitation?

Dr. KUPERSMITH. Imminently, you know, contracting determines——

Mr. STEARNS. No. Imminently is not the word.

Dr. KUPERSMITH. I cannot——

Mr. STEARNS. What is the date?

Dr. KUPERSMITH. The——

Mr. STEARNS. Imminently sounds good, but I think that is what we are asking here based upon past experience——

Dr. KUPERSMITH. This month——

Mr. STEARNS [continuing]. We want a date.

Dr. KUPERSMITH [continuing]. I mean, the contracting office is working on this and is about to release it. I cannot——

Mr. STEARNS. About to release it. I think you——

Dr. KUPERSMITH. I think you can see, sir, that I cannot give you the exact date——

Mr. STEARNS. Okay.

Dr. KUPERSMITH [continuing]. Because it is up to contracting. And it is true that there was—that is a month or less slippage and that there were improvements made in the contracting office during that time to assure that these things are done as properly as possible. And that may have been the reason for the 1-month slippage.

Mr. STEARNS. Do you set the timeline or does someone else?

Dr. KUPERSMITH. Well, we——

Mr. STEARNS. No. I mean you personally.

Dr. KUPERSMITH. I do not personally.

Mr. STEARNS. Yeah. Okay. So——

Dr. KUPERSMITH. We set it in agreement with others. And, of course, the Office of Management and Budget is part of the timeline. The Institutional Review Board reviews a part of the timeline. So, you know, we need to do patient protections. They are very important.

Mr. STEARNS. Oh, I do not discount that, but we have had a history here of slippage and malfeasance and you are aware of it. So now out of the box I see slippage again and sort of words that are not giving me assurance that this is going to be moving on a strict timeline in which somebody is going to be pushing it. So my concern is this is going to slip more and you will keep saying it is imminently going to occur and it is not. So——

Dr. KUPERSMITH. Well——

Mr. STEARNS [continuing]. Can you tell me to the best of your knowledge when the acquisition package will be released? Give me a date.

Dr. KUPERSMITH. I do not want to give you something that just comes from my head in response to your question. I mean, it will come imminently. It is not up to me to decide the date. I have been expecting it every day. And, you know, it will come very soon.

I think you can see that I cannot give you the date and I answered the question, but, I mean, it will come and we will be notifying you immediately when it comes. I think that, yes, there was a slippage of a month due to improvements in the contracting process.

Mr. STEARNS. Well, not to beat up on you too much, but the point is that 1 month, okay. But if it is going to be 2 months, could be 3 months, and I think that is what we are concerned about.

Dr. KUPERSMITH. It will not be.

Mr. STEARNS. And, you know——

Dr. KUPERSMITH. May I say that—I am sorry to interrupt you, sir.

Mr. STEARNS. That is all right.

Dr. KUPERSMITH. May I just say that it will not be 2 or 3 months.

Mr. STEARNS. Okay.

Dr. KUPERSMITH. My inability to give you an exact date tomorrow or the next day or May 12th——

The CHAIRMAN. Would you like to make a bet on what day?

Dr. KUPERSMITH. No.

The CHAIRMAN. I bet you will be too early whatever you bet on.

Dr. KUPERSMITH. Gambling is not legal, so I do not think——

The CHAIRMAN. Okay. Let us see how sure you are. Let us make a bet—your job versus my job.

Mr. STEARNS. Well, let me just conclude, Chairman, on my time that——

Dr. KUPERSMITH. No. I——

Mr. STEARNS. Dr. Kupersmith, I think when we leave this hearing, all of us want to have assurance that this is going to be pushed on time. And so——

Dr. KUPERSMITH. I understand that.

Mr. STEARNS [continuing]. You have heard——

Dr. KUPERSMITH. I am sorry.

Mr. STEARNS [continuing]. Have heard our concerns. And so my point is, just to try and reiterate, your job as knowing what the problem with malfeasance and all the things that occurred in the past that you will give us assurance this morning that you are going to be on top of the situation——

Dr. KUPERSMITH. Yes.

Mr. STEARNS [continuing]. And you are going to make sure we meet timelines. And hopefully we will get, Mr. Chairman, an interim report that we can use and help——

The CHAIRMAN. I hope we are still alive.

Mr. STEARNS. Yeah. Thank you.

Dr. KUPERSMITH. Yeah. What is not reflected in any of those timelines is the work that we have done to do just what you said.

Mr. STEARNS. Yeah.

Dr. KUPERSMITH. We have been working on this, members of our office and myself have been working on this very hard during that entire time, you know, to keep the process moving. And, yes, you are correct it was a 1-month slippage.

Mr. STEARNS. Okay. Thank you.

The CHAIRMAN. We do not know it was 1 month. It could be 12 months by the time we come around to this again.

This last exchange just proved everything I have been saying. All this talk about contracts, acquisitions, and packages, etcetera and what do you have?

You said, it is patient protection. Well, I have news for you—the ultimate patient protection is to take care of these heroes. You are not taking care of them. You are involved in this bureaucratic process that is interminable. It just restrengthens, or reinforces, my conviction that we should pass legislation that grants all of these Agent Orange claims now.

I do not care when that report is going to come back. It will slip by a month or a year. Then you will find out it is not even feasible to do the study. We will just go on and on.

You said there were people currently on the advisory panel who were on the panel from the last study. Well, I am glad they are alive because there are a lot of Vietnam veterans who are not. That is the problem and we have to cut through the bureaucracy right now.

The fact is that people are suffering and people are dying. We better take care of them now and you are not doing it.

This Committee is adjourned.

[Whereupon, at 12:35 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

I would like to thank everyone for attending today's hearing entitled, "Health Effects of the Vietnam War—the Aftermath." The stated purpose of today's hearing is to examine the health effects that our veterans sustained during the War in Vietnam as a result of being exposed to the toxic dioxin-based concoctions that we now generally refer to as Agent Orange.

As such, we will follow-up on VA's outstanding promise to finally conduct the National Vietnam Veterans Longitudinal Study (NVVLS). In this vein, we will try to stop the stovepiping in VA by also looking at how all of these issues relate to providing benefits for all Agent Orange combat veterans for presumptive conditions under current law.

I want to ensure that we do not leave any of our veterans exposed to Agent Orange while fighting overseas uncompensated for their injuries and left behind due to VA technicalities. It has been 10 long years since Congress mandated that the VA study the long-term lifetime psychological and physical health impact of the Vietnam war on the veteran of that era. In 2000, Congress required that the VA conduct a longitudinal study by building on the findings of the National Vietnam Veterans Readjustment Study of 1984.

The 1984 study was a landmark study, which provided a snapshot of the psychological and physical health of Vietnam veterans. A follow-up longitudinal study is needed to understand the life course of health outcomes and co-morbid events that have resulted from the traumas our men and women endured during the Vietnam war.

Initially the VA adhered to the letter of the law, but halted the NVVLS study in 2003 by not renewing a 3-year non-competitive sole source contract that they awarded back in 2001. The VA cited cost reasons, noting that the original estimate for completing the NVVLS had ballooned from \$5 million to \$17 million.

The VA took no further steps and ignored the law until this Committee received a proposal from former Secretary Peake in January of 2009. Former Secretary Peake recommended substituting the NVVLS with a study of twins who served in the Vietnam War and a study of women Vietnam war veterans, which would cost about \$10 million.

Given the cost of the alternative option, it seems to me that the VA could have completed the NVVLS on time had the Department chosen to allocate the \$10 million to the original contract award back in 2003.

This Committee did not see the merit of the alternative proposal and has continued to advocate for the completion of the NVVLS. In September 2009, Secretary Shinseki committed to carrying out the NVVLS study and while I applaud the Secretary for his commitment, I remain cautious and vigilant about this issue.

Through today's hearing, I would like to better understand the progress that the VA has made in conducting the NVVLS study. I also hope to learn about the potential barriers that we can proactively address so that VA remains on track to complete the study. Also, Congress passed several measures to address disability compensation issues of Vietnam veterans.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act of 1984 (P.L. 98-542) required the VA to develop regulations for disability compensation to Vietnam veterans exposed to Agent Orange.

In 1991, the Agent Orange Act (P.L. 102-4) established for the first time a presumption of service-connection for diseases associated with herbicide exposure. The Agent Orange Act authorized the VA to contract with the IOM to conduct a scientific review of the evidence linking certain medical conditions to herbicide exposure.

Under this law, the VA is required to review the biennial reports of the IOM and to issue regulations to establish a presumption of service-connection for any disease

for which there is scientific evidence of a positive association with herbicide exposure. However, VA illogically back-tracked on the Agent Orange Act regulations by reversing its own policy to move to require a “foot on land occurrence” by Vietnam veterans in order to prove service-connection. This means that the Vietnam Service Medals, etc. would no longer be accepted as proof of combat.

This change excluded nearly 1 million Vietnam veterans who had served in our Navy, Air Force, and in nearby border combat areas. This is an unfair and unjust result that has been litigated endlessly—and ultimately against these veterans. I am trying to undo this injustice in my bill, the Agent Orange Equity Act of 2009, H.R. 2254. I thank all of my fellow colleagues for their support of my bill and urge **all** Committee Members to become a co-sponsor.

Today, I hope to hear from VA why it reversed its policy that now excludes our Blue Water servicemembers from presumptive consideration for service-connection and treatment. I also want to know why it is ignoring the latest 2009 IOM recommendation that members of the Blue Water Navy should not be excluded from the set of Vietnam-era veterans with presumed herbicide exposure. I know that VA has asked the IOM to issue a report on Blue Water veterans in 18 months, but that’s 18 months too long.

The “foot on land” requirement is especially unreasonable when you consider that these servicemembers were previously treated equally to other Vietnam Veterans for benefits purposes. Moreover, several Australian Agent Orange studies long ago concluded that their Blue Water veterans who served side-by-side with our Blue Water veterans were exposed to Agent Orange and because of the water distillation process on the ships ingested it **more** directly.

While I applaud VA for recently adding the three new presumptions for Parkinson’s Disease, ischemic heart disease and B-cell leukemias for Agent Orange exposed veterans, those are three new presumptions for which Blue Water veterans may suffer and will not be treated for or compensated. I urge VA to start compensating these veterans now. Just like it reversed itself in 2002, I strongly urge VA to reverse itself now and compensate these deserving veterans.

Finally, I want to know for sure that VA plans to make sure Blue Water veterans are also included in the NVVLS so that they and their families and survivors have a chance to get the benefits they deserve on equal footing with other Vietnam veterans. I look forward to hearing from all of our witnesses today and thank you for being here to examine these long-standing issues.

Prepared Statement of Hon. John J. Hall

Thank you Mr. Chairman.

I’d like to single out the efforts of two other Vietnam veterans who brave actions this weekend saved many lives in Times Square. Today, Duane Jackson and Lance Orton are heroes all over again, and true examples of the remarkable character of the men and women who wear the uniform of our country. I have the great honor of representing Mr. Jackson in Congress, and I am sure that I join everyone here today in extending our thanks to him and Mr. Orton for their vigilance and quick thinking.

The subject before the Committee today is vitally important. The Vietnam War ended 35 years ago, but Vietnam veterans haven’t stopped suffering. The fact that we need to have this hearing now speaks to decades of inaction, dishonesty and willful ignorance regarding the devastating impacts of Agent Orange and PTSD.

However unfortunate the current state of affairs, it is clear that we need more research on the long term health effects suffered by Vietnam veterans. I commend the work of the IOM, especially the recommendations last year that found three new diseases are associated with Agent Orange. This will help thousands of sick veterans access VA health care and benefits.

Unfortunately, I find these reports to be limited because they only consider existing research. VA bills itself as a world-class health research institution. Why is VA not directing some of its resources, or sponsoring independent research, to study the full impact of a health crisis U.S. Armed Forces created for our own servicemembers?

In 1991 Congress established guidelines for the VA to determine scientifically if a particular illness or disorder is associated with Agent Orange. In a claims system that is supposed to be non-adversarial, Congress tilted the standard of proof even further in favor of veterans.

However, Congress was not able to slay one enemy that still plagues Vietnam veterans—inertia. By not mandating new research focused on the health impacts of

Agent Orange, Congress gave the VA means to stall benefits to thousands of veterans. I think the time has come for Congress to revisit that decision.

The time has also come for the VA to acknowledge that dangerous Agent Orange exposure goes far beyond veterans who set foot on Vietnamese soil. Passing Chairman Filner's Blue Water bill, H.R. 2254 would be an important step in this direction, but veterans who served in Guam, Thailand, and even airbases on U.S. soil may have been exposed to toxic herbicides. Establishing their exposure may be difficult, but we owe it to these brave men and women to raise this issue.

I strongly support restarting the National Vietnam Veterans Longitudinal Study, 8 years after Congress mandated it. I am interested in learning the VA's response to the GAO findings, given that GAO's report seems to question a number of the VA's rationales for delaying the study.

This weekend I was reminded of the hurdles still facing veterans with PTSD. An AP article took a tiny sample of fraud cases and blew them out of proportion to imply that it is too easy for veterans to receive benefits for PTSD. I think everyone in this room knows how laughable that assertion is.

Of course, the exact opposite is true. That's why I introduced the COMBAT PTSD Act and why the VA drafted a rule granting service connected disability to veterans who served in a theater of combat if they are diagnosed with PTSD.

Just this week I sat down and talked with a Vietnam veteran from my district in New York, Howard Berkowitz. Mr. Berkowitz just received a 100 percent disability rating from the VA for PTSD which he had originally applied for in 2006. Despite having a clear diagnosis of PTSD, his claim went nowhere with the VA for more than 3 years until he sought help from his Congressman.

While I was proud to help Mr. Berkowitz receive the benefits he earned, it is unacceptable that he had to wait 3 years. Veterans should not need to take the extraordinary step of involving their elected officials for help with the VA. That is a sign of a system that is broken.

The veterans covered by the topic of this hearing are the last generation to include draftees in addition to volunteers. When they returned from Vietnam, they were not welcomed home by the public, and they have been fighting their own government ever since to receive the benefits and health care they earned through service. It is long past time to remove these final barriers for Vietnam Veterans and let them finally be at peace.

Thank you Mr. Chairman.

Prepared Statement of Hon. Harry E. Mitchell

Thank you Mr. Chairman.

As you know, many veterans were exposed to the harmful toxins Agent Orange during their service in Vietnam.

Exposure to herbicides was not considered a health hazard when spraying took place.

As a result, many Vietnam veterans who were exposed to these herbicides during the War began to experience serious illnesses upon return as well as birth defects in their children.

While it has been several decades since these soldiers returned home from Vietnam, I find it unacceptable that some Vietnam veterans are still fighting the VA to get the benefits they deserve.

I believe that all Vietnam veterans who served whether in the inland waterways, the waters offshore, or the airspace above deserve benefits they have earned.

I support Chairman Filner's efforts to extend presumption of service-connection for diseases associated with herbicide exposure to those that have been previously excluded by the Department of Veterans' Affairs' narrow definition of service-connection—mostly Navy veterans.

Specifically, this bill helps to clarify Congress' intent to include all veterans who served in Vietnam as being entitled to presumptive service-connection for exposure to Agent Orange. Passing this bill honors their service to our Nation and ensures Vietnam veterans get the benefits they have earned.

Ensuring veterans get these services must remain a clear and unmistakable priority.

I look forward to hearing from today's witnesses about how we can ensure Vietnam veterans receive the benefits they have earned.

I yield back.

Prepared Statement of Hon. John H. Adler

I would like to thank Chairman Filner and Ranking Member Buyer for holding today's hearing on the Health Effects of the Vietnam War. I would also like to thank our witnesses for agreeing to testify.

We are here today for several important reasons. First, we are here to examine the health effects that Vietnam veterans sustained during that war, especially concerning their exposure to herbicides we generally refer to as Agent Orange. Second, we are here to discuss VA's exclusion of Blue Water veterans from presumption of service connection for certain illnesses. Lastly, we are here to determine why it has taken the VA nearly 10 years to conduct the congressionally-mandated National Vietnam Veterans Longitudinal Study.

Our first President, George Washington, once said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the Veterans of earlier wars were treated and appreciated by their country."

Our brave men and women sacrificed their lives and well-being to fight on behalf of our country in Vietnam. Since they have returned home, this country has been nothing short of ungrateful. We must do more for these veterans, starting with ensuring passage of Chairman Filner's *Agent Orange Equity Act*. We must honor their service to our country by extending the presumption of service-connection for diseases associated with herbicide exposure to all veterans who served in Vietnam, whether they had a "foot on land" experience or not. These veterans deserve the best medical care this grateful nation can provide. I look forward to hearing from the VA today that they are ready to justly compensate these deserving veterans.

I also look forward to getting some answers today from the VA about why they have been so resistant to conducting a study of the long-term lifetime psychological and physical health impacts of the Vietnam War on the veterans of that era. Too often, we see the VA acting against the best interests of our veterans. As members of this esteemed committee, we must remain vigilant in ensuring that the VA is acting as our veterans' advocate, not our veterans' adversary.

I look forward to hearing from our witnesses.

Thank you, Mr. Chairman.

**Prepared Statement of Richard A. Fenske, Ph.D., M.P.H., Professor and
Acting Chair, Environmental and Occupational Health Sciences,
School of Public Health and Community Medicine, University of
Washington, Seattle, and Chair, Committee on the Review of the
Health Effects in Vietnam Veterans of Exposure to Herbicides,
(Seventh Biennial Update) Board on the Health of Select Populations,
Institute of Medicine, The National Academies**

VETERANS AND AGENT ORANGE: UPDATE 2008

Good morning, Chairman Filner and Members of the Committee. My name is Richard Fenske. I am Professor and Acting Chair of the Department of Environmental and Occupational Health Sciences at the University of Washington's School of Public Health and Community Medicine. I have served on several of the Institute of Medicine's Committees to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides—as a member on the Committees that prepared *Updates 2002*, *2004*, and *2006* and as Chair of the most recent Veterans and Agent Orange (VAO) committee, which authored *Update 2008*.

The National Academy of Sciences was chartered by Congress in 1863 to advise the government on matters of science and technology. The Institute of Medicine was established in 1970 by the National Academy of Sciences to secure the services of appropriate professionals to examine policy matters pertaining to the health of the public.

I will give you a brief overview of the charge to the VAO committees and a synopsis of how these committees have approached their task. Congress established the mandate for the series of "Veterans and Agent Orange" reports in the Agent Orange Act of 1991. That legislation directed the Secretary of Veterans Affairs to have the National Academy of Sciences perform a comprehensive evaluation of scientific and medical information regarding the health effects of exposure to the herbicides used in Vietnam and then conduct updates every 2 years. The Veterans Education and Benefits Expansion Act of 2001 extended the mandate for biennial updates through

2014. Upon receiving a report from IOM, it is up to the VA Secretary to “determine whether a presumption of service connection is merited.”

The legislation indicated that, in making judgments concerning compensation of Vietnam veterans for health problems, a somewhat less stringent standard of evidence must be used than what would establish causality, as was expressed in the 1989 ruling in *Nehmer v. U.S. Veterans’ Administration*: “The legislative history, and prior VA and congressional practice, support our finding that Congress intended that the Administrator predicate service connection upon a finding of a **significant statistical association** between dioxin exposure and various diseases. We hold that the VA erred by requiring proof of a causal relationship.”

The resulting legislation directed the IOM committees to: “determine (to the extent that available scientific data permit meaningful determinations)” the following regarding associations between specific health outcomes and exposure to TCDD and other chemicals in the herbicides used by the military in Vietnam:

- A. Whether a **statistical association** with herbicide exposure exists, taking into account the strength of the scientific evidence and the appropriateness of the statistical and epidemiological methods used to detect the association;
- B. The **increased risk** of disease among those exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and
- C. Whether there exists a **plausible biological mechanism** or other evidence of a causal relationship between herbicide exposure and the disease.”

In reaching consensus about association for health effects, the Committees consider only the available scientific evidence; policy considerations definitely are not part of their deliberations.

In 1992, IOM convened a committee that conducted a comprehensive evaluation of the peer-reviewed published literature addressing association between adverse health outcomes in humans and exposure to the herbicides used by the U.S. military in Vietnam. This group established the approach that has been followed in large part by the following eight committees conducting the biennial updates.

Agent Orange was only one of several herbicide mixtures or “Agents” used in Vietnam and referred to by the color of the band on the barrels they came in. Agent Orange was a 50:50 mixture of two phenoxy herbicides, 2,4-D and 2,4,5-T, then in wide use in the United States. In addition to various combinations of the phenoxy herbicides use in other Agents, two other herbicides, picloram and cacodylic acid, were also applied in the deforestation effort. The dioxin, or TCDD, contaminating the 2,4,5-T is the component of the herbicides of most concern as a toxic chemical, but the VAO committees have also thoroughly reviewed all peer-reviewed epidemiological studies addressing these four herbicides.

Of course, the VAO committees have considered epidemiological results from studies of the Vietnam veterans themselves to be central to their decision-making. The most informative studies evaluate health outcomes in terms of serum TCDD levels as a quantitative measure of exposure, but until recently such measurements were costly, but relatively insensitive, and consequently, uncommon. As the measurement technology has improved over time, ever more half-lives for elimination have accrued and the residual levels of TCDD in potentially exposed veterans will merge with the background levels of the general public. For this reason of very scarce accurate exposure information and in accord with VA’s presumption of exposure to Agent Orange for all Vietnam veterans, the original VAO committee adopted the assumption that service in Vietnam was a proxy for potential exposure to dioxin and herbicides at levels in excess of what would have been experienced by non-deployed individuals.

Over successive updates, VAO committees have become increasingly convinced that generating estimates of risks to Vietnam veterans (overall, to particular subgroups, or individually) of developing particular health problems given as directed in Item B of their charge was intractable. Making an estimate of risk entails combining estimates of potency (per unit of exposure) for producing a given health outcome with corresponding estimates of exposure, but both these aspects of risk estimation continued to be unavailable. With the prospect of improved exposure estimates in the future being very remote, the Committee for *Update 2006* made a general statement to this effect and stopped reiterating this problem for every health outcome addressed.

In an effort to **anticipate** what herbicide-related health effects might arise in Vietnam veterans, however, the VAO committees have also factored in all relevant epidemiological information on other populations exposed to any of the five chemicals of interest. As a result, much of the most useful information has come from cohorts that were exposed before the Vietnam era, such as herbicide production workers, or from study populations whose exposures are better defined on an individual

basis, such people residing around Seveso, Italy, during or after the industrial accident in 1976.

The original VAO committee also established a set of categories of association into which any adverse health outcome could be placed on the basis of the epidemiological results found in the published peer-reviewed literature. The starting point or default category is “inadequate or insufficient evidence of an association.” VAO committees list in the inadequate category on the summary table all those health problems addressed in the text (because some epidemiological information was found) that did not present an indication of association. Any health outcome that is not a subtype of one of the illnesses mentioned and is not explicitly listed falls in the inadequate category. (Being placed in this category **does not** mean that a given health outcome is “as likely as not” to be associated with herbicide exposure, as some have interpreted the reassignment of GI cancers in *Update 2006*).

Health problems having evidence of being associated with exposure to at least one of the chemicals of interest are placed in either the “sufficient evidence” category or the “limited or suggestive evidence” category. There is not a discrete dividing point between these classifications, so the choice depends on the number, strength, and consistency of the statistics for increased risk and how well factors like bias and confounding have been accounted for in the various studies. Because of the Committee’s directive to assess statistical association (in keeping with the underlying principle of “giving the veteran the benefit of the doubt”), being placed in the “sufficient” category does not necessarily imply that a causal relationship has been established for a disease and herbicide exposure. Even the criteria for causality applied by scientific review groups do not constitute an absolute check list, and those for association are still less well defined. As to the role of Item C of the VAO committees’ charge, evidence of an association is strengthened by experimental data supporting biologic plausibility, but there is no requirement for biological plausibility for the epidemiological evidence of an association to be found either “limited/suggestive” or “sufficient.”

The original VAO committee also established a category of “suggestive evidence of **NO** association” and placed several health outcomes in it on the basis of generally negative findings for exposure to dioxin. Asserting that a negative has been established is always problematic, but for the VAO task placement in this category implies that there is **negative evidence for each** of the five chemicals of concern. With more information becoming available on the phenoxy herbicides and still virtually none on picloram or cacodylic acid, the pattern has become less clear and the Committees for successive updates have moved all but one dioxin-specific outcome back into the indeterminate “inadequate or insufficient evidence” category.

The summary chart (below) of the health effects for which the VAO committees have found the evidence for an association with herbicide exposure to be at least suggestive indicates the year of the VAO finding and any subsequent adjustment, followed by whether and when VA adopted the health condition as being presumptively associated with herbicide exposure for Vietnam veterans.

The Committee for the first comprehensive report, published in 1994, confirmed that the epidemiological evidence for association with herbicide exposure was indeed “sufficient” for the conditions that VA had previously recognized as being presumptively service-related (chloracne, soft tissue sarcoma, and non-Hodgkin’s lymphoma). In addition to finding that the evidence for statistical association was also “sufficient” for Hodgkin’s disease and porphyria cutanea tarda, the first committee reported that there was “limited or suggestive” evidence of an association with herbicide exposure for respiratory cancers, prostate cancer, and multiple myeloma. Over the course of the next seven VAO updates, with the exception of hypertension, VA has adopted as presumptively service-related all conditions listed as having either “sufficient” or “limited/suggestive” evidence of an association with herbicide exposure.

Following its review of the literature published from October 2006 through September 2008, the Committee for *Update 2008* specified two additional conditions (Parkinson’s disease and ischemic heart disease) as having “suggestive” evidence of association with herbicide exposure and concluded that hairy cell leukemia and other B-cell chronic leukemias belong with chronic lymphocytic leukemia in the “sufficient” evidence category. On March 25, VA posted a *Federal Register* notice of its intention to classify all three as presumptive.

This concludes my testimony. Thank you for the opportunity to testify. I welcome any questions the Committee may have.

Cumulative findings of IOM's Veterans and Agent Orange Committees through *Update 2008* (year of IOM finding; year of VA service connection)

Sufficient evidence of an association:

- Soft tissue sarcoma (1994; 1990)
- Chloracne (1994; 1985)
- Non-Hodgkin's lymphoma (1994; 1990)
- Hodgkin's disease (1994; 1995)
- Chronic lymphocytic leukemia (2003; 2004) (including hairy cell leukemia and other chronic B-cell leukemias) (2009; 2009)

Limited/Suggestive evidence of an association:

- Respiratory cancers—lung, larynx, trachea (1994; 1995)
- Prostate cancer (1994; 1997)
- Multiple myeloma (1994; 1995)
- Porphyria cutanea tarda (1994-suf, 1996-lim/sug; 1995)
- Early-onset transient peripheral neuropathy (1996; 1997)
- Spina bifida in the children of veterans (1996; 1996 by Congress)
- Type 2 diabetes (2000; 2001)
- [Some birth defects in the children of female veterans (—; 2000 by Congress)]
- Acute myeloid leukemia in the children of veterans (2001, retracted 2002)
- AL amyloidosis (2007; 2009)
- Hypertension (2007; —)
- Ischemic heart disease (2009; 2009)
- Parkinson's disease (2009; 2009)

Limited/Suggestive Evidence of *NO* Association:

- Skin cancer, gastrointestinal tumors, bladder cancer, brain tumors (1994, retracted 2007)
- Spontaneous abortion following paternal exposure to TCDD (2002)

Inadequate or Insufficient Evidence to Determine Association:

- Most health outcomes reviewed fall in this category because there are not enough high quality data available on the chemicals of interest to determine whether or not an association exists
- Health outcomes for which no data are available fall into this category by default

**Prepared Statement of Charles R. Marmar, M.D., Chair,
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Overview of Post-Traumatic Stress Disorder

War-zone related post-traumatic stress disorder (PTSD) is a psychiatric disorder that includes specific distressing symptoms resulting from traumatic exposure to a life threat and/or other highly distressing events during deployment, and results in impairments in work and relationship functioning. To meet diagnostic criteria for PTSD the following seven conditions must be met:

- Exposure to one or more traumatic events during which a person experiences, witnesses or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of self and others.
- At the time of traumatic exposure the person experiences intense levels of terror, horror, or helplessness.
- The traumatic event is persistently reexperienced in one or more of the following ways: recurrent unwanted memories of the event including images, thoughts and perceptions; recurrent distressing dreams of the event; acting or feeling as if the traumatic event were recurring again; intense psychological distress provoked by reminders of the traumatic event; physical reactions when reminded of the event including heart racing, sweating, and rapid breathing.
- Persistent avoidance of reminders of the event and emotional numbing as indicated by three or more of the following: efforts to avoid thoughts, feelings or conversations associated with the trauma; efforts to avoid activities, places or people that bring back memories of the trauma; difficulty recalling important aspects of the traumatic event; loss of interest or participation in previously significant and enjoyable activities; feeling distant or cut off from other people;

trouble experiencing feelings such as love or happiness; and feeling that your future will be cut short.

- Persistent symptoms of increased arousal not present before the traumatic event as indicated by two or more of the following: difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; being alert or watchful when there's no real need to be; and strong startle reactions.
- These symptoms persist for more than 1 month.
- These symptoms result in significant emotional distress, or impairment in social and occupational functioning.

In addition to these seven conditions, individuals with post-traumatic stress disorder may also describe painful feelings of guilt for surviving when others died or were more seriously injured; have difficulty regulating their emotions; may be troubled by feelings of shame and hopelessness; see the world as a dangerous, uncontrollable and unpredictable place fraught with future risks; withdraw from important family and social relationships; may experience a variety of stress related physical problems; and over time if symptoms persist, experience negative changes in personality.

Post-traumatic stress disorder may occur at any age, including during childhood and later life. The lifetime risk for PTSD in the general American population has been estimated to be 7.8 percent, with 5 percent for men and 10 percent for women. Risk factors for adult onset PTSD include exposure to traumatic events during childhood and adolescence, family history of anxiety and depression, family history of alcohol and drug abuse, female gender, lower IQ, poorer social supports before and after traumatic exposure, higher levels of stressful life events in the year before and after traumatic exposure, higher levels of terror, horror and helplessness at the time of traumatic exposure, and higher levels of dissociation at the time of traumatic exposure, including feelings that what was happening was not real (as though one were in a movie, dream or a play), feeling distant or detached from the traumatic events as they were occurring, experiencing time moving in slow motion, muffled sounds, and tunnel vision.

In the general American population, the time course for symptom duration is highly variable, with most people developing symptoms in the first month, although delayed onset 6 months or longer occurs in a minority of cases. Approximately 50 percent of individuals with civilian PTSD will recover in the first 3 months. However, recovery after 1 year is limited, with half of those with PTSD at 1 year remaining symptomatic three to 5 years or longer.

PTSD in Vietnam Veterans

Nearly 25 years ago, in response to unanswered questions concerning Vietnam Veterans' postwar adjustment, the United States Congress enacted Public Law 98-160, which directed the Veterans Administration to arrange for an independent, scientific study of the adjustment of Vietnam Veterans. The purpose of this study was to provide an empirical basis for the formulation of policy related to Veterans' psychosocial health. In response to congressional mandate, the National Vietnam Veterans Readjustment Study (NVVRS; Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar & Weiss, 1990, Jordan and colleagues, 1991) was conducted. The survey component of the NVVRS was conducted in 1986-87 with a national probability sample of Veterans who had served in the U.S. Army, Navy, Air Force or Marines between August 5, 1964 and May 7, 1975. The findings of the survey were presented to Congress in 1988. Because of its important scientific strengths, including a representative sampling of all who had served in the Vietnam War, and its comprehensive assessment using reliable and valid measures, NVVRS findings have been an important part of the foundation of a federal policy related to war veterans for more than two decades.

Highlights of the Findings of the NVVRS

- As of the time the study was conducted in 1986 and 1987, the majority of Vietnam theater veterans had made a successful reentry into civilian life and were experiencing few symptoms of PTSD or other readjustment problems.
- 15.2 percent of male Vietnam theater veterans met the criteria for current cases of PTSD, representing approximately 479,000 of the estimated 3.14 million men who served in the Vietnam theater. This compared with rates of 2.5 percent for male Vietnam-era veterans who did not serve in the Vietnam theater.
- Among Vietnam theater veteran women, current PTSD prevalence was estimated to be 8.5 percent of the approximately 7,200 women who served. This compares with rates of 1.1 percent for female Vietnam era veterans who did not serve in the Vietnam theater.

- Comparisons of current and lifetime prevalence indicated that 49.2 percent of male and 31.6 percent of female theater veterans who had developed PTSD since returning from their war-zone service still had it at the time of their 1986–87 survey interview.
- An additional 11.1 percent of male theater veterans and 7.8 percent of female theater veterans, approximately 350,000 additional men and women, suffered from partial PTSD.
- 30.6 percent of male Vietnam theater veterans and 26.9 percent of female veterans serving in the Vietnam theater met criteria for full PTSD at some time during their lives. Thus, about half of the men and one third of the women who ever developed war-zone related PTSD had PTSD at the time of the study, a decade or more after the conclusion of the war.
- Vietnam veterans with PTSD have higher rates of other specific psychiatric disorders including depression and alcohol and drug abuse, and a wide variety of other postwar readjustment problems affecting work, family functions and physical health.
- Substantial difference in PTSD prevalence rates were found by minority status. Prevalence of PTSD was estimated to be 27.9 percent among Hispanics, 20.6 percent among African-Americans, and 13.7 percent among Whites/Others. The African-American and White/Others differential rates were attributable in part to greater levels of warzone stress exposure for African-Americans. The differences between Hispanics and the other two groups could not be explained by level of warzone stress exposure.
- Interviews conducted with spouses and partners of Vietnam theater veterans with and without PTSD indicated that PTSD has a substantial negative impact not only on the veterans own lives, but also on the lives of spouses, children, and others living with Vietnam veterans with PTSD.
- At the time the survey was conducted in 1986 and 1987, very substantial proportions of Vietnam veterans with readjustment problems had never used the VA or any other source for their mental health problems, particularly during the 12 months prior to their assessment.

NVVRs Findings on the Impact of PTSD on Military Families

Post-traumatic stress disorder in those who serve in combat may have a profound effect on their relations with their spouses, partners, and children. As part of the NVVRs, spouses and partners of 376 Vietnam combat veterans were interviewed. These interviews assessed the spouses'/partners' views of family and marital adjustment, parenting problems, and interpersonal violence, as well as the spouses'/partners' view of their own mental health, drug and alcohol problems. It additionally assessed behavioral problems of school-age children living at home. Compared with families of male veterans without current PTSD, the families of male veterans with current PTSD showed markedly elevated levels of severe and diffuse problems in marital and family adjustment, parenting skills, and violent behavior.

The spouses/partners of Vietnam theater veterans with PTSD were significantly more likely to report lower levels of happiness and life satisfaction, higher demoralization scores, and higher numbers of alcohol problems. This is true despite the fact that 75 percent to 80 percent of the spouses/partners were currently working, and the majority had worked for most of their relationship with the veteran. The spouses/partners had about 13 years of education and, overall, the prestige of the spouses'/partners' occupation did not differ significantly between the PTSD and non-PTSD groups.

In addition, the children of male Vietnam veterans with PTSD had higher levels of behavioral problems than children of male Vietnam veterans without PTSD. The NVVRs findings are consistent with other published studies of the impact of combat related PTSD on family functioning. Across studies, veterans with PTSD are much more likely to report marital, parental, and family adjustment problems than veterans without PTSD. Children of veterans with PTSD are much more likely to have behavioral problems than children of veterans without PTSD, with more than one-third of all male veterans with PTSD having a child with problems in the clinically significant range.

A primary conclusion of the NVVRs findings of the impact of combat related PTSD in male Vietnam theater veterans on their families is that early treatment for those suffering the effects of combat related PTSD, including family therapy, is essential in preventing symptoms of PTSD and related psychiatric disorders from wreaking havoc on marital and family relationships.

Military Record Validation of War-zone Exposure and PTSD Rates in the NVVRS

Dohrenwend and colleagues (2006) reanalyzed the prevalence rates of PTSD in the NVVRS. They used military records to construct a new combat exposure measure that was independent of the veterans' self-report of their combat exposure and to crosscheck exposure reports and diagnoses of 260 NVVRS veterans. They found little evidence of falsification of combat exposure, and a very strong relationship between records-based severity of warzone stressor exposure and risk for PTSD. They did find adjusted PTSD rates lower than the original NVVRS results, with 18.7 percent of the veterans developing war related PTSD at some time after their return from Vietnam and 9.1 percent currently suffering from PTSD 11 to 12 years after the war. Current PTSD was associated with moderate levels of impairment.

The PTSD rates reported by Dohrenwend and colleagues can be considered a conservative, lower bound estimate of the true prevalence rates in the Vietnam theater groups. In particular, they excluded as PTSD cases those veterans with a pre-military diagnosis of PTSD. This represents a conservative bias given the extensive literature demonstrating that childhood trauma exposure is one of the best established risk factors for adult onset PTSD in both civilian and military studies (Brewin, Andrews and Valentine, 2000). The decision to exclude those with pre-combat PTSD accounts for about half of the reported prevalence differences from the original NVVRS findings. By comparison, adjustment for impairment and exposure documentation together account for only 3.8 percentage points of the reduction in lifetime prevalence and 3.1 percentage points of the current prevalence difference. In other words, half or more of the "reduction" in PTSD prevalence rates is attributable to not counting as cases those veterans who came to Vietnam with one of the most potent risk factors for PTSD.

Imperative Need to Conduct a Long-term Follow-up Study to the NVVRS

The Department of Veterans Affairs (VA) is recognized as an international leader in the study and treatment of PTSD. The NVVRS was a landmark investigation, providing definitive information about the prevalence and etiology of PTSD and other mental health and readjustment problems. Findings from the NVVRS were an important ingredient in the mix of social and political forces that brought about substantial changes in VA policy towards the postwar readjustment problems of Vietnam veterans and in the public's understanding and acceptance of the concept of PTSD. Because of the high rates of PTSD, the strong evidence for the persistence of this syndrome, and the strength of its association with war-zone stress exposure, it is imperative that the VA have information about the current functioning of the participants in the original study. This imperative is heightened by the need to understand the long-term mental and physical health consequences of war-zone related PTSD to inform strategies for preserving resilience and mitigating complications in those serving in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

The November 2000 Public Law 106-419 specified that a follow-up study be conducted utilizing the database and sample of the NVVRS study. The law specified that the study be designed to yield information on the following:

1. the long-term course of post-traumatic stress disorder in Vietnam Veterans
2. any long-term medical consequences of post-traumatic stress disorder
3. whether particular subgroups of veterans are at greater risk of chronic or more severe problems with such disorder
4. the services used by veterans who have post-traumatic stress disorder and the effect of those services on the course of the disorder.

The proposed follow-up, referred to as the National Vietnam Veterans Longitudinal Study (NVVLS) will address the aims mandated by P.L. 106-419. Specifically it will accomplish the following:

- Provide important information about the current functioning of veterans of the Vietnam War, who will be more than 20 years further downstream from their Vietnam experiences than they were at the time of the NVVRS.
- Systematically document long-term course of PTSD and other postwar adjustment problems based on the experiences of a cohort with internal and external validity unmatched in the field. Of particular interest would be new cases of PTSD, recovery or chronicity among prior cases, and the possible impact of VA programs on the course and outcome of PTSD
- The NVVLS provides an unparalleled opportunity to determine if war zone related PTSD is a risk factor for physical health problems. This concern is highlighted by recent findings: a study of Iraq and Afghanistan Veterans (Cohen

and colleagues, 2009) provided preliminary evidence for an increased risk of cardiovascular disease in those with PTSD, depression and the combination; and a VA database study of middle aged Veterans (Yaffe and colleagues, in press) reported a twofold increase in the 10 year risk for dementia in those with PTSD. The NVVLS will explore the potential association of PTSD with hypertension, adult onset diabetes, increase blood lipids, premature morbidity and death due to cardiovascular complications and the risk for early onset dementia. The power to detect these associations is greatest in veterans in their 50s, 60s and early 70s, the current age range of those originally enrolled in the NVVRS.

- Determine the long-term impact of war zone deployment on the spouses, partners and children of Vietnam veterans with and without PTSD.
- Advance the field's understanding of the etiology of PTSD in ways that cross-sectional assessments cannot.
- Determine the patterns of mental health care utilization, identify long term barriers to care, determine satisfaction with VA and other mental health services, and identify needs for future health and mental health services for aging Vietnam Veterans.

Combined Mild Traumatic Brain Injuries and PTSD

It has been proposed that the signature wound in the global war on terror is traumatic brain injury. There are multiple causes of head trauma including blast exposure, gunshot wounds, motor vehicle injury, and other accidents causing concussive injury. These are the same events that are likely to trigger terror, horror and helplessness associated with life threat exposure, creating a double jeopardy in which veterans are simultaneously exposed to the risk for PTSD and concussive head injury. As noted by Ritchie, the severely wounded are routinely screened for head trauma, however, others who may have been simply knocked unconscious for short periods of time may not present for treatment.

OEF and OIF veterans who have suffered repeated mild traumatic brain injuries (TBI), including concussions, may have gone undiagnosed in the theater. The symptoms may only surface later, after the veterans return home. Given that certain of the symptoms of mild repeated concussive head injury and post-traumatic stress disorder are similar, including concentration difficulties, sleep disruption, and irritability, and given that concussive head injuries are likely to occur in settings of a high war-zone traumatic stress exposure, veterans with dual diagnosis PTSD and TBI will present unique diagnostic and treatment challenges. As one example: cognitive behavioral treatment, the best evidence-based psychosocial treatment for PTSD, depends upon intact cognitive functioning which may be compromised following repeated closed head injuries. Repeated closed head injuries, particularly in those who are genetically vulnerable, also constitute risk factors for early cognitive decline and dementia.

The VA's recent institution of mandatory training in traumatic brain injury for health care professionals is an important step in preparing to better manage the long-term consequences of concussive injuries in the war zone.

Assessment of TBI was not a focus in the NVVRS. It will be of great interest to determine the incidence of mild TBI in the NVVLS and how closed head injuries have influenced the course of Vietnam combat related PTSD.

Importance of Conducting the NVVLS for the Readjustment of Iraq and Afghanistan Veterans

An estimated 1.9 million American men and women have served in these conflicts and are at risk for psychiatric problems. The NVVLS will generate critical knowledge about risk and resilience, course and complications of war-zone related PTSD on veterans and their families over a more than a four decade time frame. This knowledge has the potential to serve as a blueprint for better preparing for the readjustment needs of those serving in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The urgent need to plan for long-term mental health consequences of OEF and OIF is underscored by the following research findings:

PTSD in OEF and OIF Personnel

Hoge and colleagues (2004, 2006, 2007) have published studies reporting on PTSD and associated psychological problems related to combat duty in Iraq and Afghanistan. Highlights from those research findings are as follows:

- Exposure to combat was significantly greater among those deployed to Iraq than Afghanistan.
- Three to 4 months after their return from combat duty, 15.6 to 17.1 percent of those who were deployed to Iraq met screening criteria for major depression, generalized anxiety disorder, or PTSD.

- In their initial report published in 2004, only 23 to 40 percent of those who screened positive for mental health problems sought mental health care.
- Those screening positive for mental disorders were twice as likely as those screening negative for mental disorders to report concerns about possible stigmatization and other barriers to seeking mental health care.
- One year after deployment, or at the time of separation from military service if earlier than 1 year, 19.1 percent of servicemembers returning from Iraq screened positive for mental health problems compared with 11.3 percent returning from Afghanistan. Mental health problems were significantly associated with combat experiences, mental health care referral and utilization, and attrition from military service.
- 35 percent of the Iraq war veterans accessed mental health services in the year after returning home.
- Combat experienced soldiers serving in Iraq reported greater physical health complaints relative to soldiers with no prior combat experience.
- Among battle injured soldiers who served in OEF and OIF, 4.2 percent had probable PTSD at 1 month, compared with 12.0 percent at 7 months post-deployment. Among battle injured soldiers who served in OEF and OIF, 4.4 percent had probable depression at 1 month, compared with 9.3 percent at 7 months.
- Among battle injured soldiers who served in OEF and OIF, early severity of physical injuries was strongly associated with later PTSD or depression, with an important delay in the onset for symptoms in a majority of cases.
- In a sample of 2863 soldiers 1 year after their return from combat duty in Iraq, 16.6 percent met screening criteria for PTSD. PTSD was significantly associated with lower ratings of general health, more sick call visits, more missed workdays, more physical symptoms, and higher somatic symptom severity. These results remained significant after controlling for being wounded or injured.
- High prevalence rates of physical health problems among Iraq veterans with PTSD 1 year after deployment have important implications for delivery of medical services, including the importance of DoD primary care screening of those who present with physical symptoms for combat related PTSD.

Recently Seal and colleagues (in press) investigated longitudinal trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans. Among 289,328 Iraq and Afghanistan veterans entering Veterans Affairs (VA) health care from 2002 to 2008 using national VA data, 106,726 (36.9 percent) received mental health diagnoses; 62,929 (21.8 percent) were diagnosed with post-traumatic stress disorder (PTSD) and 50,432 (17.4 percent) with depression. Adjusted 2-year prevalence rates of PTSD increased 4 to 7 times after the invasion of Iraq. Active duty veterans younger than 25 years had higher rates of PTSD and alcohol and drug use disorder diagnoses compared with active duty veterans older than 40 years (adjusted relative risk = 2.0 and 4.9, respectively). Women were at a higher risk for depression than were men, but men had over twice the risk for drug use disorders. Greater combat exposure was associated with higher risk for PTSD.

Limitations of Current Studies of Readjustment of OEF and OIF Veterans; Relevance for Conducting the NVVLS

A recent Institute of Medicine (IOM) report notes that the majority of studies of OEF and OIF Veterans have relied on samples of convenience, limiting their external validity, and limiting generalizability to all men and women who have served in active duty, guard and reserve components. The studies to date have for the most part relied on brief screening instruments to identify key outcomes and to estimate prevalence, which limits internal validity. The use of cross-sectional designs limits the ability to support causal inference and to elucidate the course of disorders. The NVVRS, if complimented with the NVVLS, will provide critical lessons learned for anticipating the long-term readjustment needs of OEF and OIF veterans and will inform resource allocation in planning for health care services. Of note, because the NVVLS will be a longitudinal study of a true probability sample of all who served in Vietnam, it is the only design option which will address all of the internal and external validity concerns raised by the IOM report.

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**Prepared Statement of Randall B. Williamson, Director, Health Care,
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**VA HEALTH CARE: Progress and Challenges in Conducting the National
Vietnam Veterans Longitudinal Study**

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the National Vietnam Veterans Longitudinal Study (NVVLS). According to the Department of Veterans Affairs (VA), experts estimate that up to 30 percent of Vietnam veterans have experienced post-traumatic stress disorder (PTSD), an anxiety disorder that can occur after a person is exposed to a life-threatening event.¹ Veterans suffering from PTSD may experience problems sleeping, maintaining relationships, and returning to their previous civilian lives.² Additionally, studies have shown that many veterans suffering from PTSD are more likely to be diagnosed with cardiovascular disease and other diseases.

After the Vietnam War, Congress wanted information about the psychological effects of the war on Vietnam veterans to inform the need for PTSD services at VA. Consequently, in 1983, Congress mandated that VA provide for the conduct of a study on PTSD and related postwar psychological problems among Vietnam veterans.³ VA contracted with an external entity, the Research Triangle Institute, to conduct the National Vietnam Veterans Readjustment Study (NVVRS).⁴ According to VA, the NVVRS was a landmark study and is the only nationally representative study of PTSD in Vietnam veterans. PTSD is an ongoing concern for Vietnam veterans, and today, Vietnam-era veterans still constitute the largest group of veterans

¹Unless otherwise noted, Vietnam veterans refers to those who served in Vietnam during the Vietnam era, from February 28, 1961, through May 7, 1975. See 38 U.S.C. §101(29). Estimates for Vietnam veterans who have experienced PTSD vary. For example, according to the Centers for Disease Control and Prevention's 1989 *Vietnam Experience Study*, about 15 percent of Vietnam veterans have experienced PTSD. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (Washington, D.C., 2000).

²Those diagnosed with PTSD may also suffer from other ailments, such as depression and substance abuse.

³Veterans' Health Care Amendments of 1983, Pub. L. No. 98–160, § 102, 97 Stat. 993, 994–95. This law defined Vietnam veterans as those who served in Vietnam or elsewhere in the Vietnam theater of operations from August 5, 1964, through May 7, 1975, the Vietnam era. See 38 U.S.C. §101(29) (1982).

⁴Other collaborators, such as Louis Harris and Associates, Inc., and The Graduate Center of the City University of New York, were also involved in conducting the NVVRS.

receiving VA care for PTSD.⁵ Congress and others have been concerned about the continued prevalence of PTSD and VA's capacity to meet the needs of Vietnam veterans. In section 212 of the Veterans Benefits and Health Care Improvement Act of 2000, Congress required that VA contract with an appropriate entity to conduct a follow-up study to the NVVRS.⁶ The law specifies certain requirements that the follow-up study must meet, including that the study must use the database and sample of the NVVRS and be designed to yield information on the long-term effects of PTSD and whether particular subgroups were at greater risk of chronic or more severe problems with PTSD. In 2001, VA awarded another contract to the Research Triangle Institute to plan and conduct a follow-up study, the NVVLS.⁷ However, in 2003, before data collection for the study began, VA terminated the contract and the study was not completed.⁸ In September 2009, the Secretary of Veterans Affairs announced that the agency planned to award a new contract to an external entity to conduct the NVVLS.

My testimony is based on our May 2010 report,⁹ which is being released today, and discusses two issues related to VA's current efforts to address the law: (1) the recent progress VA has made in conducting the NVVLS and (2) the challenges VA faces in its plans to conduct the NVVLS.

To obtain information about VA's progress in conducting the NVVLS and its challenges, we interviewed VA officials responsible for managing VA's PTSD research, including officials on the project team responsible for restarting the NVVLS.¹⁰ We also interviewed VA officials who are conducting VA's studies of PTSD in male twin Vietnam-era veterans and female Vietnam-era veterans. In addition, we obtained and reviewed relevant documents regarding VA's PTSD research studies, including a draft performance work statement¹¹ and progress report for the NVVLS, study protocols for the studies on male twin Vietnam-era veterans and female Vietnam-era veterans,¹² and other documents related to the study methodologies. In order to understand how the NVVLS will be conducted, we also obtained and reviewed information about the NVVRS and the 2001 NVVLS attempt.

To provide context for the information we obtained from VA, particularly about VA's reported challenges in conducting the NVVLS, we interviewed 10 researchers who are currently involved in or have previously been involved in managing or conducting PTSD research.¹³ The criteria we used to select the researchers we interviewed included expertise in PTSD, as indicated, for example, by service on national committees focused on veterans and PTSD, and knowledge of or involvement with the NVVRS, the 2001 NVVLS attempt, or the NVVLS. We chose these researchers to represent a range of perspectives on the studies we examined: for example, we interviewed both researchers who are currently employed by VA and researchers who are not employed by VA. To obtain additional perspectives on study design techniques and feasibility issues, we also interviewed three Department of Health and Human Services methodologists: two from its Agency for Healthcare Research and Quality and one from its Centers for Disease Control and Prevention.¹⁴

⁵When we use "Vietnam-era veteran" in this testimony, we are using the current governing definition: from February 28, 1961, through May 7, 1975, for veterans who served in Vietnam, and from August 5, 1964, through May 7, 1975, for veterans who served in any other location. See 38 U.S.C. § 101(29).

⁶Pub. L. No. 106-419, § 212, 114 Stat. 1822, 1843-44. Throughout this testimony, we refer to section 212 as the law.

⁷A longitudinal study approach involves the repeated examination of a set of study participants over time.

⁸In this testimony, we use "2001 NVVLS attempt" to refer to the efforts that began in 2001 to complete the NVVLS. After the contract was terminated, VA's Office of Inspector General investigated the 2001 NVVLS attempt. The resulting 2005 report found that VA did not properly plan or administer the study contract. It recommended that VA use appropriate contracting processes to complete the mandated follow-up study. See Department of Veterans Affairs, Office of Inspector General, *Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study* (2005).

⁹GAO, VA Health Care: Status of VA's Approach in Conducting the National Vietnam Veterans Longitudinal Study, GAO-10-578R (Washington, D.C.: May 5, 2010).

¹⁰The NVVLS project team is composed of 14 individuals, including 7 VA officials who are handling various aspects of the study, 3 VA representatives who are subject matter experts, 2 non-VA representatives who are subject matter experts, and 2 facilitators.

¹¹A performance work statement, also known as a statement of work, is a description of the work the government expects the contractor to perform.

¹²A study protocol is a document that describes the formal design of a research study.

¹³We contacted a total of 13 researchers, but 3 researchers declined to speak with us. Two of them felt unable to provide specific comments on our issues, and the third stated that he did not have time to speak with us.

¹⁴In addition, we interviewed representatives of two veteran service organizations, the Vietnam Veterans of America and Disabled American Veterans, in order to obtain their perspectives

We conducted this performance audit from October 2009 through April 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found that since September 2009, VA has taken a number of steps toward conducting the NVVLS. VA convened a project team for the NVVLS consisting of VA officials and PTSD experts both within VA and outside of VA. According to VA officials, the NVVLS project team developed a performance work statement, which outlines VA's requirements for the contractor selected to conduct the NVVLS.¹⁵ VA expects to select a contractor for the NVVLS in the summer of 2010 and for the NVVLS to be completed in 2013. VA officials stated that they plan for the NVVLS to meet all of the requirements of the law where scientifically feasible. In addition, VA is conducting studies of PTSD in male twin Vietnam-era veterans¹⁶ and female Vietnam-era veterans,¹⁷ and VA officials maintain that these studies will also provide useful information in response to the law.

VA reported that it faces several challenges in restarting the NVVLS. However, in several instances, the researchers and methodologists we interviewed offered suggestions for how these challenges could be addressed. The challenges reported by VA included the following:

- *Locating and gaining consent from NVVLS participants.* VA officials stated that they did not know how many of the NVVRS participants can be located and would agree to participate in the NVVLS, which could impact the feasibility of the study. While 6 of the 10 researchers and the 3 methodologists we interviewed agreed that it could be challenging to locate the original participants, 9 of the researchers offered suggestions for overcoming this challenge, such as using the data sources and methods from previous successful efforts to reconnect with study participants and taking advantage of current technology.¹⁸ All 10 researchers and 3 methodologists stated that to encourage participation, it was important for NVVLS participants to receive assurances of confidentiality—that is, assurances regarding use of their identifying information, as was done with the NVVRS participants.¹⁹ According to VA's draft performance work statement for the NVVLS, the NVVLS consent form will not contain these assurances of confidentiality but it will state that study participation will not affect participants' VA benefits or VA health care. However, the draft performance work statement also states that the agency plans to take possession of study participants' identifying data at the conclusion of the NVVLS. While nine of the researchers commented that this requirement could impact whether veterans would agree to participate in the NVVLS, VA stated that it conducts many internal research studies and has no material issues recruiting study participants due to mistrust of VA.
- *Mitigating possible bias in a follow-up study.* VA officials said that there could be bias in the NVVLS because the NVVRS was not designed to accommodate a follow-up study. The three methodologists we interviewed stated that this challenge was closely related to the challenges of locating the original participants and obtaining their agreement to participate in the study—that is, bias

on the concerns and needs of veterans with PTSD. We also contacted representatives from the American Legion.

¹⁵We reviewed a draft version of this performance work statement.

¹⁶This study, officially titled "A Twin Study of the Course and Consequences of PTSD in Vietnam Era Veterans," began in 2006 and is projected to finish in 2013. The objectives of the study are (1) to estimate the longitudinal course and current prevalence of PTSD; (2) to identify the relationships between the longitudinal course of PTSD and veterans' current mental and physical health conditions, such as cardiovascular disease, diabetes, depression, and substance use disorders; and (3) to identify the relationships between PTSD and veterans' current functional status and disability. VA estimates that 5,306 men will participate in the study. This study defines the Vietnam era as 1965 through 1975.

¹⁷This study, officially titled "Long Term Health Outcomes of Women's Service During the Vietnam Era," began in 2008 and is projected to conclude in 2014. The study will examine the following issues in Vietnam-era female veterans: (1) the prevalence of lifetime and current psychiatric conditions, including PTSD; (2) physical health; and (3) the level of current disability. According to VA, approximately 7,000 women will participate in the study. This study defines the Vietnam era as July 4, 1965, through March 28, 1973.

¹⁸The one researcher who did not offer a suggestion stated that VA may not be able to overcome the challenge.

¹⁹The NVVRS provided participants with assurances of confidentiality via the NVVRS consent form, which stated that their identifying information would not be disclosed in any government proceedings.

will be present in the NVVLS if representative participation across the subgroups included in the NVVRS is not achieved.²⁰ The methodologists stated that if bias in the NVVLS is a concern, VA could survey additional individuals from the general Vietnam-era population to supplement the original NVVRS cohort or develop a new sample of participants from the general Vietnam-era population for the NVVLS. VA's draft NVVLS performance work statement states that the contractor can choose to examine all or some of the NVVRS participants, but does not address the question of whether the contractor could propose to survey other Vietnam-era veterans.

- *Assessing PTSD in the NVVLS.* VA officials were concerned about appropriately assessing PTSD in the NVVLS. Because there was no widely accepted PTSD screening method at the time the NVVRS was conducted, the study's estimates of PTSD prevalence were based on a multimeasure approach involving the use of 10 PTSD assessment instruments administered to a subset of NVVRS participants by doctoral-level mental health professionals. VA officials stated that this complex approach has not been used in other PTSD studies and would not be desirable to replicate. Nine of the 10 researchers we interviewed stated that the multimeasure method used to identify PTSD in the original study was not of concern.²¹ In order to provide comparable longitudinal data, 9 of the researchers and 2 of the methodologists we interviewed recommended that the NVVLS contractor use PTSD assessment instruments similar or identical to those used in the NVVRS in addition to more current approaches.²² According to the NVVLS draft performance work statement, the PTSD instruments used in the NVVRS should be used in the NVVLS, when appropriate, to enhance consistency and facilitate long-term analyses. The draft performance work statement also recommends that newer measures should be included when possible.

Overall, VA officials do not know whether, given the challenges they face, the NVVLS can be completed. VA's NVVLS draft performance work statement includes an initial phase during which VA expects the contractor to assess the feasibility of the study. All 10 researchers we interviewed said that restarting the study soon is important because as the study participants continue to age, an increasing number will be lost for follow-up because of illness or death.²³ Nine of the researchers told us that they believe it is important for VA to complete the NVVLS because it will potentially provide important, nationally representative information on PTSD and related issues in Vietnam-era veterans.

In responding to a draft of the report from which this testimony is based, VA explained its position on the ownership of the NVVRS and NVVLS study data. VA stated that the NVVRS contract provided that the study data was the property of the agency and did not provide that the identifying information be kept from VA. The agency also stated that the NVVRS consent documents did not restrict VA from possessing the identifying information of participants. VA confirmed that the agency intends to receive all the NVVLS study data, including participants' identifying information, upon completion of the study, and stated that the NVVLS consent form will explain to participants that VA does not intend to use the data to determine eligibility for VA benefits.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions you or other Members of the Committee may have.

Contacts and Acknowledgments

For further information about this testimony, please contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Individuals who made key contributions to this testimony include Mary Ann Curran, Assistant Director; Susannah Bloch; Stella Chiang; Martha R. W. Kelly; Lisa Motley; Rebecca Rust; and Suzanne Worth.

²⁰The NVVRS was required by law to provide information on certain subgroups, specifically veterans with service-connected disabilities, female veterans, and minorities.

²¹One researcher thought the method used to identify PTSD in the NVVRS was of concern because the PTSD assessment instruments used in the method lacked validity. However, this researcher acknowledged that these instruments may have been the best available at the time.

²²One researcher said that this approach would not necessarily be recommended because it may burden the participants and reduce participation rates.

²³The youngest Vietnam-era veterans still living today would be approximately in their early 50s. During the 2001 NVVLS attempt, the researchers estimated that 8.5 percent of the Vietnam-era veterans who originally participated had died.

Prepared Statement of Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America

Chairman Filner, Ranking Member Buyer, and distinguished Members of this committee, on behalf of our officers, Board of Directors, and members, thank you for allowing Vietnam Veterans of America (VVA) the opportunity to present our testimony today regarding the implementation of the health effects of the Vietnam War and the efforts to discern those effects, including the National Vietnam Veterans Longitudinal Study.

National Vietnam Veterans Longitudinal Study

No one really knows how many of our troops in Iraq and Afghanistan have been or will be affected by their wartime experiences, despite the early intervention by psychological personnel. No one really knows how serious their emotional and mental problems will become, nor how chronic the neuro-psychiatric wounds (particularly PTSD) and the resulting impact that this will have on their physiological health. However, reports from researchers at Walter Reed have suggested that troops returning from service in Afghanistan and Iraq are suffering mental health problems at rates at least comparable to or higher than the levels seen in Vietnam War veterans, if indeed not higher rates.

There is no reason to believe that the rate of veterans of this war having their lives significantly disrupted at some point in their lifetime by PTSD will be any less than those estimated for Vietnam veterans by the National Vietnam Veterans Readjustment Study. There is mounting peer reviewed evidence that the incidence of PTSD will be even greater than in the Vietnam generation, largely because of ever longer exposure to hostile action.

Results from the original NVVLS which was conducted more than 20 years ago demonstrated that some 15.2 percent of all male and 8.5 percent of all female Vietnam theater veterans were current PTSD cases, e.g., at some time during 6 months prior to interview. Rates for those exposed to war zone stress were dramatically higher—a four-fold difference for men and seven-fold difference for women—than rates for those with low or moderate stress exposure. Rates of lifetime prevalence of PTSD were 30.9 percent among male and 26.9 among female Vietnam theater veterans. Comparisons of current and lifetime prevalence rates indicate that 49.2 percent of male and 31.6 percent of female theater veterans, who ever had PTSD, still had it at the time of their interview. Thus the NVVLS was a landmark investigation in which a national random sample of all Vietnam theater and era veterans, who served between August 1964 and May 1975, provided definitive information about the prevalence and etiology of PTSD and other mental health readjustment problems. The study over-sampled African-Americans, Latinos, and Native Americans, as well as women, enabling conclusions to be drawn about each subset of the veterans' population.

The NVVLS enabled the American public and medical community to become aware of the documented high rates of current and lifetime PTSD, and of the long-term consequences of high stress combat exposure. Because of its scope, the NVVLS has had a singular effect on VA policies, health care delivery, and service planning. In addition, because the study clearly demonstrated high rates of PTSD and strong evidence for the persistence of this disease, it was generally accepted that the VA would pursue a follow-up, or longitudinal, study of the original participants in this seminal research project.

Thus in 2000, Congress, by means of Public Law 106-419, mandated the VA to contract for a subsequent report, using the same participants, to assess their psychosocial, psychiatric, physical, and general well-being. Such research would become a longitudinal study of the mortality and morbidity of the participants, and draw conclusions as to the long-term effects of service in the military as well as about service in the Vietnam combat zone in particular. The law requires that the VA use the previous report, and the same sample population, as the basis for the longitudinal study.

In early 2001, the VA solicited proposals for non-VA contractual assistance to conduct a longitudinal study of the physical and mental health status of a population of Vietnam era veterans originally assessed in the NVVLS. It is apparent that a follow-up to the NVVLS is necessary to meet the requirements of the law, and to do what just makes sense in both policy and scientific terms. However, not only has the VA failed to meet the letter of the law, there has been no effort to build upon the resources accumulated from this unique and comprehensive study of Vietnam veterans in a highly cost-efficient and scientifically compelling manner.

A longitudinal study would provide clues about which VA health care services are effective and about ways to reach veterans who receive inadequate services or do

not seek them at all. This has important consequences for America's current veterans, and for future veterans not to mention the casualties returning today from the wars in Iraq and Afghanistan.

At that same hearing on Research & Development on June 7, 2006, the VA also said that it could not conduct the study because staffers could only find 300 of the original more than 2,500 persons in the statistically valid random sample chosen by the Gallup Organization at a public cost of more than \$1 million in 1984 dollars. If that were true (which strains credulity at best), then that would mean that 85 percent of that valid national sample have died in the past 25 years. VVA would suggest that, if true, this should be front-page news. The VA has claimed in the past that they would be better off using the widely discredited and failed "Twins" study data base from the Centers for Disease Control and Prevention (CDC) that has no women at all and not nearly enough African-Americans, Hispanics, or Asian-Americans to make valid conclusions. Furthermore, the twins "sample of convenience" database is so small that it is not a statistically valid random sample for anybody. One can speculate that the VA has refused to obey the law because officials do not want a longitudinal study, or perhaps they do so because they do *not* want validation of the results of what the NVVLS may demonstrate in regard to high mortality and morbidity of Vietnam veterans, especially those most exposed to combat.

It is now clear that the VA has been ignoring the law and the Congress and just plain refusing to undertake the study, until recently. It also seems clear that some in the VHA hierarchy intend to continue delaying the study and/or doing everything they can to stop the study from being done correctly, despite the orders from Secretary Shinseki last September 15. Clearly the senior officials in the Office of Research & Development (ORD) think they can act this way with impunity, and so far there has been no action or repercussions from this "slow rolling" dilatory behavior to disabuse them of their hubris.

The VA has said in past Congressional testimony that "the Inspector General stopped the study," when in fact the Inspector General (IG) has no line authority to do any such thing. The then Undersecretary and Secretary halted the study. The only real criticism by the IG was for VHA failing to follow proper contract procedures or exercise proper oversight. The VA convinces no one that this decision is anything by the so-called permanent bureaucracy to try and minimize possible future costs to the VA by underestimating the needs of combat veterans.

It has now come to our attention that the VA, though their contract officer is apparently still demanding of the Research Triangle Institute (RTI) to know the names and social security numbers of the participants in the original study, who had been assured anonymity. Previous as well as current VHA leaders not only have tried to besmirch the reputation of this respected research institution by citing things in a report by the VA IG that the report did not contain, but now they are threatening RTI with legal and or other punitive actions, through the VA contract officer, if they don't violate privacy rights of the participants in this study. This unconscionable effort to compromise the study population, to violate basic scientific principle of protection of human subjects, as well as an effort to again violate the privacy rights of the individuals concerned, must be stopped by Congress before the VA totally mucks things up and precludes a proper follow-up study ever being done on this population.

Secretary Shinseki ordered VHA and ORD to move forward to complete the replication of the National Vietnam Veterans Readjustment study, thereby making it a robust longitudinal mortality and morbidity study of Vietnam veterans (NVVLS), has resulted in inaction since he announced the order to proceed on September 15 of last year. There has not even been a "Sources Sought" notice put out to discover which private research institutions might be interested in this contract, much less any concrete action in the almost 7 months since the announcement. We are somewhat baffled as to why this clear thwarting of a direct order of the Secretary is allowed to continue.

With your strong support, we are hopeful that the VA will finally do the right thing and finish this study and intended by the Congress, and observe scientific ethics in doing so. The results of this study are vitally important to this Committee and to all stakeholders and policy makers as plans for the future of VA services are being made now.

Agent Orange

VVA reiterates our strong support for early passage of H.R. 2254, the Agent Orange Equity Act. We must do whatever needs to be done, in this 35th year since the end of the Vietnam war, to ensure that these veterans receive some measure of justice as soon as possible.

Vietnam Veterans of America is the only veterans service organization who is a member of the **Research!America**, which is the Nation's premier consortia of groups that strongly favor and advocate for increased medical research in America. Our commitment to this effort is unflagging.

Mr. Chairman, there may well be much that is excellent and deserving of great respect in the VA Research program. However, most of it has little or nothing to do with the wounds, maladies, injuries, illnesses, and conditions that stem from military service.

VA is currently funding no research into the long term effects of Agent Orange, nor are they funding any research into the long term effects of exposure to environmental toxins in Gulf War I that may be causing Gulf War illness.

VA celebrated Research week in the latter part of April, spending a good deal of money and effort to run this self-congratulatory in regard to all the wonderful research they are doing that benefits veterans. It is, however, not much more than "spin." VVA has inquired as to how much money all of this "hoopla" costs, including staff time, but has yet to receive an answer.

For the second year in a row VVA did not participate nor support this effort, because VA ORD leadership continues to act in an irresponsible manner toward Vietnam veterans, as well as other generations of veterans, by willfully ignoring the adverse health conditions of veterans and our families resulting from exposure to toxins during military service. Therefore our decision to not support VA's effort was not taken lightly, but only after numerous years of unresponsiveness on the part of the current head of ORD.

We have brought this lack of proper focus in research to the attention of the current Secretary of Veterans Affairs, as well his last four predecessors, but the pattern does not seem to fundamentally change.

The position of the VA and of the Federal Government is untenable, and just not honest on the face of it. First the Federal Government does not fund any research into the long term adverse health effects of Agent Orange on Vietnam veterans (or our progeny), and then claims that there is no scientific proof of any adverse health effects on Vietnam veterans, nor our children and grandchildren. Clearly Dow Chemical is not going to fund this research. Any reasonable and honest person knows this. Therefore this position amounts to "willful ignorance." We would suggest that the only unpardonable sin is willful ignorance in the face of gross injustice.

After much thought and discussion within VVA it is clear that while pressing for enactment of the pending legislation we must forge a contingency plan that will achieve the same purpose. The analogy would be that while many of us still believe that health care funding for veterans should be mandatory, we supported Advance Appropriations in the meantime.

As the Members of this Committee no doubt know, all of the National Institutes of Health (NIH) have two basic sections of their budget: one is for intramural research performed with full time scientists employed by that institute as the principal investigator; and, two, extramural research whereby they put out grants to universities and other private and public research entities. VA only has an intramural research program at present. Much of the money in this program goes to the "stars" at medical schools that are affiliated with a VA Medical Center, whether it has anything in particular to do with the wounds, maladies, injuries, illnesses, and adverse health conditions that may be attributable to military service or not.

Clearly what is needed is the creation of an office of extramural research at VA that has totally separate leadership that the current leadership of ORD. Said office should be structured in such a way that there is strong input from the veterans' community and from the elements of the scientific community outside of government that have a good track record in regard to this kind of research that is focused on the wounds, maladies, injuries, illnesses, and adverse medical conditions that result from military service, depending on when and where one served as well as one's job (MOS) in such service. Further, said office should be contracting for epidemiological studies of various groupings of veterans, and use that information to inform the priorities for further research to be funded.

Additionally, the need is for full disclosure of all use of any form of Agent Orange, other herbicides, or pesticides, or other toxins, wherever they were used in the world on military bases. There is absolutely no national security reason that would legitimately prevent such full disclosure. During the Vietnam war, there is reported use of herbicides in Thailand, Okinawa, the Philippines, Guam, and many other locations on the Pacific rim. There is also evidence that in addition to Eglin AFB there was extensive use of said herbicides on other military bases in CONUS during the same time period. This evidence from DoD records must be made available to VA, as well as to the public, prompting action by the Secretary to extend service connected presumption to veterans who served in those locations.

It is also clear that there is strong evidence, reinforced by the latest Institute of Medicine (IOM) report that the so-called “blue water” Navy veterans should be included in the group of those who are included in the presumptive group of those who are considered to be “in-country” Vietnam veterans for purposes of service connection, along with their brethren in the Army and Marines. The evidence from the desalinization units on board ships resulting in even higher exposure to dioxin than many on land is clear.

Mr. Chairman, again all of us at VVA thank you for this opportunity to present our testimony before you today. I will be pleased to answer any questions that you or your distinguished colleagues may have.

**Prepared Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs
and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present the American Legion’s views on the National Vietnam Veterans Longitudinal Study and illnesses associated with exposure to Agent Orange.

The American Legion supported Public Law (P.L.) 96–151, which mandated that the Department of Veterans Affairs (VA) to conduct a major epidemiological study of Vietnam veterans who were exposed to dioxin, an impurity in the herbicides sprayed by the United States (U.S.) military stationed in Vietnam.

One of the top priorities of the American Legion continues to assure that long-overdue, major epidemiological studies of Vietnam veterans, who were exposed to the herbicide Agent Orange, are carried out. Shortly after the end of the Vietnam War, Congress held hearings on the need for such epidemiological studies. The Veterans’ Health Programs Extension and Improvement Act of 1979, P.L. 96–151, directed VA to conduct a study of long-term adverse health effects in veterans, who served in Vietnam, as a result of exposure to herbicides. When VA was unable to do the job, the responsibility was passed to the Centers for Disease Control (CDC). In 1986, CDC also abandoned the project, asserting that a study could not be conducted based on available records. The American Legion did not give up though. Three separate panels of the National Academy of Sciences have agreed with the American Legion and concluded that CDC was wrong and that epidemiological studies based on Department of Defense (DoD) records are possible.

The Institute of Medicine (IOM) report entitled *Characterizing Exposure of Veterans to Agent Orange and Other Herbicides Used in Vietnam* (2003) is based on the research conducted by a Columbia University team. Headed by principal investigator Dr. Jeanne Mager Stellman, the team has developed a powerful method for characterizing exposure to herbicides in Vietnam. The American Legion is proud to have collaborated in this research effort. In its final report on the study, the IOM urgently recommends that epidemiological studies be undertaken now that an accepted exposure methodology is available. The American Legion strongly endorses this IOM report.

Meanwhile, VA estimates 2.6 million Vietnam veterans were exposed to Agent Orange. Currently, approximately 900,000 Vietnam veterans are alive and eligible for treatment of exposure to Agent Orange-related illnesses. To date, the study has not been completed.

From 1962 to 1971, the United States military used various blends of herbicides to remove foliage from trees that provided cover for the enemy. One of these herbicides was labeled as Agent Orange. These herbicides have been associated with various illnesses affecting veterans who served in the Vietnam. The following illnesses are currently recognized by VA as being associated with exposure to herbicides used in Vietnam:

- Acute and Subacute Peripheral Neuropathy
- AL Amyloidosis
- Chloracne (or Similar Acneform Disease)
- Chronic Lymphocytic Leukemia
- Diabetes Mellitus (Type 2)
- Hodgkin’s Disease
- B Cell Leukemias (Pending Final Regulation)
- Ischemic Heart Disease (Pending Final Regulation)
- Multiple Myeloma
- Non-Hodgkin’s Lymphoma
- Parkinson’s Disease (Pending Final Regulation)

- Peripheral Neuropathy (acute or subacute)
- Porphyria Cutanea Tarda
- Prostate Cancer
- Respiratory Cancers
- Soft Tissue Sarcoma (other than Osteosarcoma, Chondrosarcoma, Kaposi's sarcoma, or Mesothelioma)
- Spina Bifida in children of veterans (not including spina bifida occulta)

Children of Vietnam Veterans and Spina Bifida

In 2003, the American Legion supported and endorsed the expansion of spina bifida benefits, as set forth in H.R. 533, the Agent Orange Veteran's Disabled Children's Benefits Act of 2003, to a person suffering from spina bifida who is a natural child, regardless of age or marital status, of a parent who performed "qualifying herbicide-risk service," provided the individual was conceived after such service. A parent would be considered to have performed "qualifying herbicide-risk service" if, while performing active military, naval, or air service, the parent "served in an area in which a Vietnam-era herbicide agent was used during a period during which such agent was used in that area; or . . . otherwise was exposed to a Vietnam-era herbicide agent." Spina bifida is a neural tube birth defect that results from the failure of the bony portion of the spine to close properly in the developing fetus during early pregnancy.

According to VA, it is the most frequently occurring permanently disabling birth defect; affecting approximately one of every 1,000 newborns in the US. Although Vietnam veterans are almost out of the age category for having children, VA reports that some future births will occur and some of these children may have birth defects, to include spina bifida. **The American Legion urges Congress to amend title 38, Chapter 18, to provide entitlement to spina bifida benefits for the child or children of any veteran exposed to a Vietnam-era herbicide agent, such as Agent Orange, in any location, including those outside of Vietnam, where herbicides were tested, sprayed, or stored.**

Children of Vietnam Veterans and Type II Diabetes

In 2001, VA added type II diabetes to the list of "presumptive diseases associated with exposure to herbicides in Vietnam." This action was in response to a report by the IOM that found "limited/suggestive" evidence of an association between the chemicals used in herbicides during the Vietnam War, such as Agent Orange, and Type II diabetes. Type II Diabetes occurs mainly in adults, however, a CDC report revealed it is becoming more common among youth and adolescents.

It is the American Legion's contention that more conclusive research be conducted to determine if the effects of exposure to herbicides in Vietnam affected the offspring of those who served.

Children of Women Vietnam Veterans

Under P.L. 106-419, the Veterans Benefits and Health Care Improvement Act of 2000, VA also identified birth defects of children of women Vietnam veterans that:

- Are associated with service in Vietnam.
- Result in permanent physical or mental disability.

The American Legion supported the above piece of legislation and urges Congress to include research involving:

- Women veterans who served in Vietnam to include, in country and other locations, and were exposed to herbicides.
- Children of both men and women veterans who served in Vietnam, to include, in country and other locations, and were exposed to herbicides.

Blue Water Navy

IOM, in Update 2008, specifically stated that the evidence it reviewed makes the current definition of Vietnam service for the purpose of presumption of exposure to Agent Orange, which limits it to those who actually set foot on land in Vietnam, "seem inappropriate." Citing an Australian study on the fate of the contaminant TCDD when sea water is distilled to produce drinking water, an IOM committee stated that it was convinced that such a process would produce a feasible route of exposure for Blue Water veterans, "which might have been supplemented by drift from herbicide spraying." (See IOM, Veterans and Agent Orange, Update 2008, p. 564; July 24, 2009.) IOM also noted that a Centers for Disease Control and Preven-

tion study in 1990, found that non-Hodgkin's lymphoma, a classic Agent Orange cancer, was more prevalent and significant among Blue Water Navy veterans. IOM subsequently recommended that, given all of the available evidence, Blue Water Navy veterans should not be excluded from the group of Vietnam-era veterans presumed to have been exposed to Agent Orange/herbicides. **The American Legion submits that not only does this latest IOM report fully support the extension of presumption of Agent Orange exposure to Blue Water Navy veterans, it provides scientific justification to the legislation currently pending in Congress that seeks to correct this grave injustice faced by Blue Water Navy veterans.**

In December 2009, IOM created a VA sponsored committee to further explore the Blue Water Navy exposure issue. The duration of this project is to last 18 months. According to IOM, their report will include the following:

- Historical background on the Vietnam War, Combat troops, Brown Water Navy, Blue Water Navy.
- Discussions on comparison of herbicides exposure to Blue and Brown Water Navy veterans; examination of the range of exposure mechanisms for exposures, to include toxics in drinking water and air exposure from drifts from spraying; food; soil, and skin.
- Conclusion on the comparative risks for long-term health outcomes comparing Vietnam veteran ground troops; Blue Water Navy veterans; and other "Era" veterans serving during the war in Vietnam at other locations.
- A complete review of studies of Blue Water Navy veterans for health results.

The American Legion looks forward to the completion of this project.

Herbicides Used Outside of Vietnam

The American Legion is also extremely concerned about the timely disclosure and release of all information by DoD on the use and testing of herbicides in locations other than Vietnam during the war. Over the years, the American Legion has represented veterans who claim to have been exposed to herbicides in places other than Vietnam. Without official acknowledgement by the Federal Government of the use of herbicides, proving such exposure is virtually impossible. Information has come to light in the last few years leaving no doubt that Agent Orange, and other herbicides contaminated with dioxin, were released in locations other than Vietnam. This information is slowly being disclosed by DoD and provided to VA.

In April 2001, officials from DoD briefed VA on the use of Agent Orange along the Korean Demilitarized Zone (DMZ) from April 1968 through July 1969. It was applied through hand spraying and by hand distribution of pelletized herbicides to defoliate the fields of fire between the front line defensive positions and the south barrier fence. The size of the treated area was a strip 151 miles long and up to 350 yards from the fence to north of the civilian control line.

According to available records, the effects of the spraying were sometimes observed as far as 200 meters downwind. DoD identified units that were stationed along the DMZ during the period in which the spraying took place. This information was given to VA's Compensation and Pension Service, which provided it to all of their Regional Offices. VA Central Office has instructed its Regional Offices to concede exposure for veterans who served in the identified units during the period when the spraying took place.

In January 2003, DoD provided VA with an inventory of documents containing brief descriptions of records of herbicides used at specific times and locations outside of Vietnam. The information, unlike the information on the Korean DMZ, does not contain a list of units involved or individual identifying information. Also, according to VA, this information is incomplete, reflecting only 70 to 85 percent of herbicide use, testing and disposal locations outside of Vietnam. VA requested that DoD provide it with information regarding units involved with herbicide operations or other information that may be useful to place veterans at sites where herbicide operations or testing was conducted. Unfortunately, as of this date, additional information has not been provided by DoD.

Obtaining the most accurate information available concerning possible exposure is extremely important for the adjudication of herbicide-related VA disability claims of veterans claiming exposure outside of Vietnam. For herbicide-related disability claims, veterans who served in Vietnam during the period of January 9, 1962 to May 7, 1975 are presumed, by law, to have been exposed to Agent Orange. Veterans claiming exposure to herbicides outside of Vietnam are required to submit proof of exposure. This is why it is crucial that all available information relative to herbicide use, testing, and disposal in locations other than Vietnam be released to VA in a

timely manner. **The American Legion urges congressional oversight to assure that additional information identifying involved personnel or units for the locations already known by VA is released by DoD, as well as all relevant information pertaining to other locations that have yet to be identified. Locating this information and providing it to VA must be a national priority.**

Department of Veterans Affairs (Readjustment Studies)

In September 2009, VA announced plans to restart the follow-up to the 1984 National Vietnam Veterans Readjustment Study, known as the National Vietnam Veterans Longitudinal Study (NVVLS). In its announcement, VA stated NVVLS will study the Vietnam generation's physical and psychological health. In addition, the new study will supplement research already in progress at VA, to include studies on post-traumatic stress disorder (PTSD) and the health of women Vietnam veterans.

The Veterans Administration (now known as VA) initiated the National Vietnam Veterans Readjustment Study in 1984 as a result of a congressional mandate. Until the NVVLS completion in 1988, this study included utilization of a nationally representative sample of male and female veterans. Following the 1984–1988 study P.L. 106–419 required VA to contract with a non-VA entity to conduct a new approach. In addition, P.L. 106–419 required the new study to employ the database and sample population from the original Readjustment Study.

In January 2001, the Veterans Health Administration (VHA) assigned the project to the Mental Health Strategic Healthcare Group (MHSBG) to plan and manage the study. The MHSBG, then, created a management structure to oversee the study, to include:

- An Executive Committee comprised of the Readjustment Counseling Director (Vet Center), three mental health professionals from different VA medical facilities, and a veterans' service organization (VSO) representative.
- A Project Coordinator and Project Officer; both having served in the same capacities during the original Readjustment Study.
- A Scientific Advisory Board of 10 expert consultants in various disciplines, to include cardiology-epidemiology, psychiatry, and biomedical statistics (A similar advisory board had also been used for the original Readjustment Study).

Later in 2001, VHA allotted \$4.9 million and awarded a noncompetitive contract to the Research Triangle Institute (RTI) to conduct the study, to include \$460,000 for Fiscal Year (FY) 2001. However, in 2003, after the RTI had worked for more than 2 years, VA chose not to exercise the third-year of the contract. This was due to concerns of lack of competition in the contract award, as well as estimated costs of completing the study, which had increased from the original estimate of \$4.9 million to \$17 million. VA ultimately ruled that the study was not properly planned, procured or managed, and ordered that it be completed; in the interim they were making provisions to avoid these same problems.

The American Legion, as before and at the onset of all Agent Orange-related illnesses, will continue to closely monitor the development of all ongoing research on the long-term effects of Agent Orange exposure and disclose all findings to Congress regarding any perceived deficiencies or discrepancies; and to ensure that Federal Government committees charged with review of such research are composed of impartial members of the medical and scientific community.

The American Legion/Columbia University Study

In 1983, the American Legion initiated a joint study with Columbia University to ascertain the effects of exposure to service in Vietnam on veterans of the Vietnam War. The joint study facilitators were Columbia University Drs. Jeanne Stellman and Steven Stellman. The study, a cross-sectional survey of then current and past health status among members of the American Legion, compared veterans who served in Southeast Asia with those who served in locations outside of Southeast Asia. The results of the study revealed serious combat-related mental, physical and social problems. Veterans, who served in heavily-spread areas, had poorer general health. The studies also showed that veterans were not satisfied with the services provided by VA. A follow-up study conducted in 1998 showed that many of the health effects had endured over the decades.

Conclusion

The American Legion believes the new study facilitators should take heed of the circumstances prompting the abrupt halt of the 2001 NVVLS study. When studies, such as those involving Agent Orange and of the more than 900,000 Vietnam veterans, are proposed and/or conducted, we must keep in mind that other circumstantial processes, to include funding and contracting, should be properly planned, executed, and maintained. Otherwise, opportunities for inclusion of new illnesses are missed, resulting in thousands of affected veterans going without treatment.

Other additional consideration placed on the new study includes the fact that the previous NVVLS was concluded in 1988. **The American Legion urges Congress to insist on the assessment and review, with all pertinent parties, of all VA-sponsored and IOM studies, to fulfill the most recent charge by VA to ensure no evidence and information is lacking.**

To prevent that which occurred with the incomplete 2001 NVVLS Study, the American Legion encourages proper congressional oversight, as well as continuous inclusion of stakeholders, such as veterans' service organizations. Since 1990, when the American Legion brought suit against the U.S. government for failure to carry out its congressionally-mandated Agent Orange study, the American Legion remains steadfast in its belief that such studies are needed. **The American Legion firmly believes Congress should exercise congressional oversight to make sure these studies, it has mandated, are carried out. We also urge timely disclosure of ongoing studies by IOM, through Veterans and Agent Orange (VAO) update publications; promptly every 2 years, as directed by P.L. 107-103, Veterans Education and Benefits Expansion Act of 2001.**

Mr. Chairman and Members of the Committee, the American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on the abovementioned matters and issues of similarity. Thank you.

Prepared Statement of Commander John B. Wells, USN (Ret.), Cofounder and Trustee, Veterans Association of Sailors of the Vietnam War

Good Morning Mr. Chairman and Members of the Committee. I appreciate this opportunity to speak with you on behalf of the Veterans Association of Sailors of the Vietnam War concerning the "Health Effects of the Vietnam War—The Aftermath." I intend to address my remarks in support of those who have been left behind. We continue to stand with all veterans Blue Water Navy, Blue Sky Air Force, Thailand, Laos and Cambodia veterans in seeking the enactment of H.R. 2254 so that benefits to all groups may be quickly restored. Our friends and allies, the Australians, who fought beside us on land and at sea in Vietnam and every conflict subsequent to Vietnam, have taken the lead in granting Agent Orange benefits to those who served outside of the land mass of Vietnam. They have also taken the lead in the scientific research in this field, which has recently been validated by our own Institute of Medicine.

By way of introduction, my name is John B. Wells and I am a retired Navy Commander as well as an attorney. I entered the Navy in February of 1972 and was commissioned an Ensign in June of 1973. In June of 1974 I completed the Main Propulsion Assistant course and was assigned to the USS *Holder* (DD-819) as Main Propulsion Assistant. Ships of that class served frequently on the gun line off the coast of Vietnam in its territorial waters. The ship's distilling plant/evaporators (hereinafter distillers) were part of the equipment under my purview. In October of 1976 I transferred to the USS *Coronado*, (LPD 11) also as Main Propulsion Assistant. In the fall of 1977 I was reassigned as Chief Engineer after that Engineer was detached for cause. I guided the ship through a successful Operational Propulsion Plant Examination. Again, the ship's distillers were part of the equipment under my purview. Later I was asked to oversee the preparation of the ship's repair plan for the upcoming shipyard overhaul. While I was onboard, the ship deployed to the Caribbean and to the Mediterranean.

After a 2 year shore assignment, I was assigned to the Surface Warfare Officers School Department Head Course. That course included several months of engineering training as well as combat systems and fundamentals. I was assigned to the USS *Badger* (FF-1071) as Operations Officer. I was also in charge of the ship's shipyard overhaul. When the *Badger's* Chief Engineer was fired, I was assigned to that position. Again, the ship's distillers were part of the equipment under my purview. I guided the ship through a successful Light Off Examination and Operational Pro-

pulsion Plant Examination. In 1982, I was assigned to the USS *Worden*, (CG-18) as Chief Engineer. I was responsible for the ship's distillers. *Worden* made deployments to the Western Pacific, Indian Ocean and the North Arabian Sea.

In late 1984, I was reassigned to the staff of the Commander Naval Surface Reserve Force. My responsibilities included the operation and scheduling for nineteen ships of the Naval Reserve Force. In 1987, I was assigned to the pre-commissioning unit of Battleship *Wisconsin* (BB-64) as Main Propulsion Assistant. I served as Acting Chief Engineer for a number of months until the Engineer reported. Again, the ship's distillers were part of the equipment under my purview. I was later reassigned as Executive Officer (second in command) of the USS *Puget Sound* (AD-38). *Puget Sound's* mission was the repair of other ships. The ship deployed to the North Atlantic and Indian Ocean-Persian Gulf while I was on board.

In 1989 I was reassigned as Commanding Officer, Naval Reserve Readiness Center Pittsburgh, PA. At this time I began attending law school during the evening. Part of my responsibilities was the training of over 1000 reservists. We developed many training courses including engineering courses to include ship's distillers. I retired from the Navy, as a Commander on 1 August, 1994. I graduated from Duquesne Law School with a Juris Doctor approximately 6 weeks prior to my retirement.

In the Navy I was qualified as a Surface Warfare Officer, Officer of the Deck (underway), Combat Information Center Watch Officer, Command Duty Officer, Tactical Action Officer, Navigator, and Engineering Officer of the Watch. I was also qualified for command at sea. I received a mechanical engineering subspecialty based on significant experience. My ships operated with units of the Royal Navy and the Royal Australian Navy. This included NATO exercises, RIMPAC exercises and other multi-national exercises and global operations.

The history of the blue water Navy tragedy begins in Australia. In the late 1990s, the Australian Department of Veterans Affairs noticed a significant number of Agent Orange related cancers in Royal Australian Navy veterans who had never set foot on land in Vietnam. Dr. Keith Horsley of the Australian Department of Veterans Affairs met Dr. Jochen Muller of the National Research Centre for Environmental Toxicology and the Queensland Health Services (hereinafter NRCET) at a conference in Stockholm. Dr. Horsley addressed the phenomena with Dr. Mueller who agreed to conduct a study to explore the reasons for this apparent dichotomy. Dr. Horsley arranged for funding from the Australian Department of Veterans Affairs and commissioned NRCET to explore the mystery. Their report, entitled the *Examination of The Potential Exposure of Royal Australian Navy (RAN) Personnel to Polychlorinated Dibenzodioxins And Polychlorinated Dibenzofurans Via Drinking Water*, (NRCET study) was published in 2002. I have talked with the authors of that report via telephone and e-mail. My wife, who is a Louisiana notary and paralegal, and also an Australian native, traveled to Brisbane to interview the authors of the report.

At about the same time the NRCET report was published, the American Department of Veterans Affairs issued a change to their Adjudication Procedures Manual (M21-1 Manual) that deleted those soldiers, sailors and airmen who did not set foot on land in Vietnam from the presumption of herbicide exposure. This decision later led to the litigation discussed below.

As a threshold matter, the vessels of both Australian and American origin operated side by side in the waters adjacent to Vietnam. The missions were driven by the ship capabilities and not by nationality. There was no tactical differences between the operations conducted by ships of the United States and Royal Australian Navy.

The NRCET study noted that ships in the near shore marine waters collected waters that were contaminated with the runoff from areas sprayed with Agent Orange. NRCET Study at 10. The authors later reported to this office that estuary containing the dioxins extended more than three nautical miles from shore. This means that the contamination would have extended well past the gun line which was normally located 2000 to 5000 yards from shore. The distilling plants aboard the ship, which converted the salt water into potable drinking water, actually enhanced the effect of the Agent Orange. NRCET Study at 42. The study found that there was an elevation in cancer in veterans of the Royal Australian Navy which was higher than that of the Australian Army and Royal Australian Air Force. NRCET Study at 13. This was confirmed by the "*The Third Australian Vietnam Veterans Mortality Study*" (hereinafter 2005 Mortality Study). The NRCET Study at page 35 noted significant concentrations at Vung Tau, an area visited by Australian and American ships. Theories that the Agent Orange stopped at the water's edge are simply preposterous. Congress in enacting the Clean Water Act recognized that pollutants discharged from shore will contaminate the navigable waters, waters of the contiguous

zone, and the oceans. Anecdotal evidence reports Agent Orange in the waters of the rivers which then empty out into harbors and eventually the estuarine waters. Sailors aboard the HMAS *Sydney* noted that brown water runoff would go many kilometers out to sea. 2005 Mortality Study at 196. Da Nang harbor was identified as a serious Agent Orange “hot spot.” Anecdotal evidence noted that clouds of Agent Orange were blown out to sea. Approximately 10–12 percent of the land area was sprayed with Agent Orange. In contrast everyone aboard a ship that distilled contaminated water from estuarine sources was exposed.

The distillers all work on similar principles to produce water (feed water) for the boilers and potable water for the ship’s crew. Water is introduced from the sea and is passed through the distilling condenser and air ejector condenser where it acts as a coolant for the condensers. It is then sent through the vapor feed heater into the first effect chamber and into the second effect chamber where it is changed to water vapor. Vapor then is passed through a drain regulator into a flash chamber and passes through baffles and separators into the distilling condenser where it is condensed into water and pumped to the ship’s water distribution system. Sea water not vaporized is pumped over the side by the brine pump. *Id.* This is the same process discussed in the NRCET Study. It was used by American, British and Australian ships. In fact many Royal Australian Navy ships were retired United States Navy ships or ships of the same class as the American ships. Those that were not of American design were often constructed by the British. They all used the same system. This system was used well into the 1990s. More recently a new system, reverse osmosis, is being adopted, but that did not see service during the Vietnam War.

Potable water was manufactured continuously along with “feed” water for the ship’s boilers. It was a constant headache and as a Chief Engineer there were many times that I was given round the clock hourly briefings on the status of water. This was especially true in southern latitudes such as Vietnam since the higher ambient sea water temperatures reduced the efficiency of the distilling process.

As discussed in the NRCET Study the distilling process enhanced the effect of the dioxin. Additionally the dioxin was ingested orally through drinking water, food, oral hygiene etc. On land, the dioxin, once sprayed, would become embedded in the soil. Since the water systems of the ships would have been thoroughly contaminated, the dioxin would have adhered to piping and continued to contaminate in an ever increasing amount. The authors confirmed this in their discussions with my office. The cumulative effect of the contamination would have resulted in a very high concentration. It would have taken weeks and perhaps months to completely flush the system once the ship moved away from contaminated waters. The Australian study confirmed the enhancing effects of the shipboard distilling plants. NRCET Study at 42. In other words, the effect was even more pronounced than if the veteran had merely ingested Agent Orange by breathing it or by drinking water from a contaminated stream.

In their publication in the *Federal Register*, Vol. 73, No. 73, of April 15, 2008, the Department of Veterans Affairs complained that the NRCET study was not peer reviewed. Actually it was peer-reviewed and published. The report was presented to the 21st International Symposium on Halogenated Environmental Organic Pollutants and POPs in Gyeongju Korea on 9–14 September 2001. It was then published in Volume 52 of *Organohalogen Compounds* (ISBN 0–9703315–7–6) which is published by Dr. Jae Ho Yang, Catholic University of Daegu, Korea. Please see <http://espace.library.uq.edu.au/view/UQ:95837> (last visited June 13, 2008). More importantly, the study was prepared at the request of and for the Australian Department of Veterans Affairs who accepted the study. The study was cited in “*The Third Australian Vietnam Veterans Mortality Study*” (hereinafter 2005 Mortality Study) published in 2005 by the Department of Veterans’ Affairs and Australian Institute of Health and Welfare and resulted in the Department’s consideration of Royal Australian Navy Vietnam Veterans as potentially exposed Vietnam Veterans. The study was further reviewed at the request of the Institute of Medicine’s Agent Orange Committee, by Dr. Steven Hawthorne of the University of North Dakota. He certified that the NRCET study was scientifically viable and that the conclusions, based on Henry’s Law were correct.

In their *Federal Register* article, the DVA asserted that:

“VA’s scientific experts have noted many problems with this study that caution against placing significant reliance on the study. In particular, the authors of the Australian study themselves noted that there was substantial uncertainty in their assumptions regarding the concentration of dioxin that may have been present in estuarine waters during the Vietnam War.”

This is a blatant misrepresentation of the author's position. When Dr. Caroline Gaus, one of the report's author was questioned on this point, she replied as follows:

"The problem referred to in this comment is associated with estimating the exposure level of Vietnam Veterans, not with the study's primary finding that exposure to dioxins was likely if (i) drinking water was sourced via distillation and (ii) the source water was contaminated. As highlighted by the authors, the exact level of exposure via this pathway is uncertain due to the lack of data on contaminant levels in the source water during the Vietnam War. The attempt made by the study to estimate the level of exposure serves only as an indication that exposure may have been considerable (and depends on the concentrations in the source water). Hence, the problem lies in the lack of exposure information, not with the study. The study clearly demonstrates that if source water is contaminated, dioxins are expected to co-distill with drinking water.

This issue is also not related to the study's quality, but rather highlights one of its findings out of context. The study noted that, while increasing suspended sediment loads in the source water decreases the co-distillation of dioxins, dioxins still co-distill with water at the highest level of suspended sediment in the water tested (i.e. at 1.44 g/L 38 percent of 2,3,7,8-TCDD co-distilled in the first 10 percent of source water). If 10 percent of the source water is distilled, TCDD would enrich in the drinking water by a factor of almost 4 compared to the source water. This was confirmed by using water from a tropical estuary with naturally high suspended sediment loading, where 48–60 percent of TCDD co-distilled with the first 10 percent of source water.

As noted above and in the study itself, estimating the level of exposure via this pathway is difficult due to the lack of data on the concentrations of dioxins in the source water. The level of exposure would depend strongly on the dioxin concentrations in the source water (which would have varied from location to location) as well as on the amount and duration of water consumed for drinking and/or cooking.

The study attempted to provide an estimate on the concentrations of dioxins in source water (0.043–0.69 ng/L). While the uncertainty around this value is large (approximately in the order of a factor of 10 or more), it cannot be determined whether it represents an over- or underestimate (which would also depend on location). Hence, it would be difficult to determine whether the level of exposure was similar, higher or lower compared to veterans who served on land. However, the study demonstrates that exposure is likely to have occurred if source water was contaminated and suggests that exposure may have been considerable.

Notably the study *Identification of New Agent Orange/Dioxin Contamination Hot Spots in Southern Viet Nam Final Report conducted by Hatfield Consultants* in 2006 noted significant hot spots in the land and waters internal to Vietnam, including Da Nang harbor. Concentration levels were still significant, over 30 years after the end of the war.

The DVA *Federal Register* comment contained the curious remark that one had to assume that the sailors drank only the contaminated water and only for an extended period of time. That is a safe assumption. All Navy ships manufacture potable drinking water from sea water. This water is replenished almost daily. These ships did not have the capacity to carry potable water throughout the voyage without replenishment via their distillers. These ships patrolled the entire coast of Vietnam and often anchored in harbors to provide gunfire support. To infer that these ships never steamed through contaminated waters is naive. Additionally, there was no means to transport large quantities of water outside of the reserve potable water tanks. Nor was there a long water hose connecting the ship with Hawaii.

As previously discussed the NRCET study was cited in the 2005 Mortality Study. That study was conducted by the Australian Institute of Health and Welfare for the Australian Department of Veterans Affairs. It found a 19 percent increase in mortality for Navy veterans over the Australian population. This is despite the fact that mortality among Vietnam veterans as a whole was lower than the general Australian community. In another study, *Cancer Incidence in Vietnam Veterans 2005* (hereinafter the 2005 Cancer Study), the Australian Department of Veterans Affairs again cited the NRCET study. The 2005 Cancer Study found that Royal Australian Navy veterans had the highest rate of cancer, higher than expected by 22–26 percent, followed by Army veterans, higher than expected by 11–13 percent and Air

Force veterans with a 6–8 percent higher than the expected rate of cancer. Navy and Army veterans showed a higher than the expected incidence of cancers of the colon, oral cavity, pharynx and larynx and cancers of the head and neck and gastrointestinal. Whereas Navy veterans demonstrated a higher than the expected incidence of gastrointestinal cancer, Army and Air Force veterans showed higher than the expected incidence of Hodgkin's disease and prostate cancer. The cancers unique to the Navy would appear to support the ingestion of the dioxin orally rather than nasally.

Notably, cancer in Navy veterans could not be attributed to the ship on which they served or the time spent in Vietnamese waters. This would indicate, I believe, that the contamination of the waters was extensive and the contamination of the water storage and distribution system long lasting. Although the passage of time has made it impossible to produce direct proof, the circumstantial evidence is certainly compelling.

The Australians have stepped forward and began granting benefits to those who had served (i) on land in Vietnam, (ii) at sea in Vietnamese waters, or (iii) on board a vessel and consuming potable water supplied on that vessel, when the water supply had been produced by evaporative distillation of estuarine Vietnamese waters, for a cumulative period of at least 30 days. They have defined Vietnamese waters as an area within 185.2 kilometers from land (roughly 100 nautical miles). In reliance upon the NRCET Study, they began promulgating Statements of Principles, which are similar to our Code of Federal Regulations, covering various cancers. For several years now, Australian Navy veterans have been receiving benefits denied to their American counterparts.

In the summer of 2008, I presented to the Institute of Medicine's (IOM) Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides (Seventh Biennial Update) in San Antonio, Texas. We provided them with copies of the NRCET study, the VA's *Federal Register* notice and reclamation, by myself and Dr. Gaus. The IOM Committee conducted an exhaustive review of the NRCET study and requested an independent review by Dr. Steve Hawthorne who is the Senior Research Manager of the Energy & Environmental Research Center (EERC), University of North Dakota. Dr. Hawthorne's principal areas of interest and expertise include environmental chemistry and analysis, and supercritical and subcritical (superheated) fluid extraction. After reviewing the NRCET study, Dr. Hawthorne reported:

. . . that leaves two questions to be answered:

1. Is there a physiochemical basis to expect that non-polars (like the dioxins) would distill, while polars (like dimethylarsenic acid) do not distill?
2. Do their experiments confirm expectations based on physiochemical parameters that dioxins distill and DMA does not?

The answers to both questions are definitely yes. An explanation of these results can be based on Henry's law—i.e., the tendency of a solute to evaporate from water. This tendency is enhanced by high vapor pressure (obviously), but also by low water solubility. Thus, even molecules like 2,3,7,8-TCDD that have high boiling points will evaporate from water because their solubility is so low. Conversely, molecules like DMA that are very soluble in water do not evaporate from water. The fact that non-polar molecules (even those with high boiling points) evaporate from water is well-known in environmental science, and has been demonstrated to occur with a broad range of pollutants such as PCBs, PAHs, organochlorine pesticides, as well as dioxins. For example, the EPA estimates that the half-life for evaporation of 2,3,7,8-TCDD from a pond is 46 days. The distillation process greatly enhances this process by adding heat and reducing the pressure. The experiments described confirm expectations based on Henry's law that dioxins would be concentrated in the distillate, while DMA would not. (The formation experiment was inconclusive, but I don't believe it is important to their conclusions.) Assuming that their apparatus mimics ship-board units (and that seems reasonable), the increased concentration of dioxins in distillate water should be accepted to a reasonable scientific certainty.

The IOM report accepted the proposition that Navy veterans off the coast were exposed and recommended that they be given the presumption of exposure. In their recommendation, the IOM committee stated: "Given the available evidence, the Committee recommends that members of the Blue Water Navy should not be excluded from the set of Vietnam-era veterans with presumed herbicide exposure."

Although the DVA accepted other recommendations from this IOM report, including the extension of benefits for ischemic heart disease, Parkinson's disease and B cell leukemia such as hairy cell leukemia. Inexplicably the Department of Veterans Affairs refused to accept the IOM report, instead ordering another study by a different committee of the IOM to review areas previously addressed by the Agent Orange Committee and the Australians. The study was commissioned in February of this year and is expected to take 18 months. Meanwhile, our Navy veterans are dying of Agent Orange-related diseases.

The Department of Veterans Affairs has undertaken a project to cover some blue water Navy veterans. If a ship entered inland waters, such as a river, the presumption is granted. This is a classic case of doing the right thing for the wrong reason. It is doubtful that the distillers, designed to convert salt water to fresh, would have been operating in the rivers. More importantly, Navy regulations at the time stated potable water should not be distilled in rivers, streams etc. This project, while covering a few more veterans, is a mere extension of the DVA's irrational "boots on the ground" requirement.

This project is complicated by the difficulty in proving ships' locations. Logs are not always available and are handwritten. Specific locations are not always identifiable. Locations are often specified by directional bearings and/or ranges to navigational points that may no longer exist or may be called by a different name. Personnel going ashore are never documented unless they are permanently reporting to or transferring from the command. The project has resulted in a massive expenditure of time with little reward.

I would be remiss if I did not address the case of *Haas v. Peake*, 525 F.3d 1168 (Fed. Cir. 2008). I filed an amicus brief in *Haas* which centered on international law and the NRCET study. The presumption issue in *Haas* was a secondary issue. Actually Commander Haas was directly exposed from an airborne cloud.

The *Haas* case was primarily decided on administrative law principles dealing with rulemaking. In revising their M21-1 Manual, the DVA failed to follow the rulemaking provisions of the Administrative Procedures Act (APA). The Court of Appeals for Veterans Claims found that the provision was irrational and not promulgated pursuant to law. The Court of Appeals for Veterans Claims had also ruled that the Department of Veterans Affairs' interpretation of the enabling statute, 38 U.S.C. § 1116, which excluded the Navy veterans, was unreasonable and inconsistent.

The Federal Circuit excused the VA's compliance with the rulemaking provisions of the APA. Acting on administrative law principles, it also reversed the Veterans Court holding that the DVA was not given sufficient deference in the way they interpreted the statute. The Federal Circuit relied upon the "*Chevron* doctrine," that states "when an agency invokes its authority to issue regulations, which then interpret ambiguous statutory terms, the courts defer to its reasonable interpretations." In a split (2-1) decision, the Federal Circuit held that the DVA was entitled to *Chevron* deference because they found that the phrase "served in the Republic of Vietnam in section 1116 is ambiguous." It was this curious finding which caused the predecessor of H.R. 2254 to be introduced in the last session, and H.R. 2254 in this session, to clarify the "ambiguous" language.

In my amicus brief I raised the argument that the statutory language incorporated the territorial seas. U.S. Navy ships, like their Australian counterparts, steamed within the territorial waters of Vietnam. Territorial waters were historically defined as (1) the water area comprising both inland waters (rivers, lakes and true bays, etc.) and (2) the waters extending seaward three nautical miles from the coast line, i.e., the line of ordinary low water, (ofttime called the 'territorial sea'). Seaward of that three-mile territorial sea lie the high seas. *C. A. B. v. Island Airlines, Inc.* 235 F.Supp. 990, 1007 (D.C. Hawaii 1964). A wider area, the contiguous zone, reaches out to 12 miles from the coast. *United States v. Louisiana* 394 U.S. 11, 23 n. 26. (1969). Vietnam claimed a 12-mile territorial sea limit, which defines its sovereignty. That is consistent with the limitations of the United Nations Convention on the Law of the Sea Article 3. Three nautical miles is within the outermost range of the 5"38 gun mounts of Destroyer type ships used in the Vietnam war. Twelve nautical miles (24,000 yards) is beyond the maximum range of the most commonly used shipboard batteries, the 5"38 or the 5"54 naval gun. The same holds true for the 6" and 8" guns. Only the Battleship could provide support beyond 12 miles.

The enabling statute, 38 U.S.C. § 1116(a)(1)(A) recognizes a presumption of service connection when the veteran manifests an enumerated disease, if the person was "a veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7,

1975.” The threshold factors are the existence of a prescribed disease and service in Vietnam.

In *Louisiana v. Mississippi*, 202 U.S. 1, 52 (1906), the Supreme Court held that the Mississippi Sound, and by extension the waters surrounding all harbors as inland waters, were under the category of “bays wholly within [the Nation’s] territory not exceeding two marine leagues in width at the mouth.” Inland, or internal waters are subject to the complete sovereignty of the Nation, as much as if they were a part of its land territory. *United States v. Louisiana*, *supra*. Thus the presumption should apply to *any harbor* as well as inland waters. The territorial waters to include the contiguous zone are also under the control of the sovereign nation, although innocent passage may not be denied. *Id.* Subject to the right of innocent passage, the coastal state, in this case Vietnam, has the same sovereignty over its territorial sea as it has with respect to its land territory. *See*, 1958 Territorial Sea Convention Article 1–2; Law of the Seas Convention, Article 2.

Thus any time a Navy ship was firing its guns ashore, it would have had to have been within the territorial waters of Vietnam. When at anchor in a harbor, it was within the inland waters of Vietnam. At all relevant times, the ship was within the sovereignty of Vietnam and therefore its crew “served in the Republic of Vietnam.” The distance to shore directly corresponds to the maximum range of the support of forces ashore. Consequently, most naval units operated close to shore. Gunfire missions were often shot from two to three thousand yards of the shore, well within the three nautical mile limit. Many were anchored in Da Nang Harbor. The closer a ship was to the coast, the higher the possibility that they steamed through waters contaminated with Agent Orange. In the case of the harbor anchorages, the ships were not only within the sovereign territory of Vietnam, they were within the inland waters. Under both national and international law, most ships served in the Republic of Vietnam. The Federal Circuit, in ruling on a petition for rehearing, refused to address the international law arguments, stating that Mr. Haas had waived the argument by not presenting it at the Veterans Court.

After the submission of all briefs and a few days before the May 8, 2008 decision was rendered, the Department of Justice, acting on behalf of the DVA, submitted a supplemental brief based on the erroneous April 15, 2008 *Federal Register* notice. Although the information in that article has since been refuted, there was not sufficient time to respond to the supplemental brief. This left the Court under the impression that the NRCET study had not been peer reviewed, that the Australians used different ships and distilling systems, that American ships did not make water and that the authors doubted their own study. Those impressions were blatantly false, but this was not brought before the Court. Although not a holding of the Court, the DVA misrepresentations were discussed in *dicta* and obviously had some impact on the decision.

While this adversarial ploy was a brilliant tactical move, it was a reprehensible act by an agency who claims to stand as a non adversary to care for the veteran, his widow and orphan. I am reminded of Justice Black’s dissent in *St. Regis Paper Co. v. United States*, 368 U.S. 208, 229 (1961). “Our Government should not by picaunish haggling over the scope of its promise, permit one of its arms to do that which, by any fair construction, the Government has given its word that no arm will do. It is no less good morals and good law that the Government should turn square corners in dealing with the people than that the people should turn square corners in dealing with their government.”

These men left their homes to go to war. It was an unpopular war, but they went. There were teach-ins telling them how to dodge the draft or flee to Canada. But they went. When they returned they were spat upon and called the most terrible of names. But they went. These men were and are casualties of war. Many have died and others are dying. Their names will never go on the Wall, but they are casualties who have had or will have their lives cut short. In the midst of recession they are left without medical care. Their families are left without support as they pass. These men are heroes and we owe them medical care and a pension.

Currently Australia recognizes a presumption of exposure for all of those who served within the 185.2-kilometer radius of Vietnam for 30 days or more. That is roughly the same area as the Vietnam Service Medal area. While I am certainly happy that our Allies have taken the step of compensating and treating their Navy veterans, as an American, I am somewhat chagrined that we did not immediately follow suit. As the leader of the Free World, we should take the lead in taking care of our veterans.

It is impossible to provide direct evidence as to the dioxin content of the South China Sea and the waters off Vietnam in the 1960s and 1970s. Too much time has passed to be able to make that determination. The circumstantial case, however, is compelling. The 2005 Mortality Study and Cancer Incidence Study identified an ex-

posure problem unique to the Navy. The NRCET study shows how exposure most probably occurred. The type of cancers developed by Australian Navy veterans confirm that exposure did occur.

H.R. 2254 is designed to correct years of neglect and degradation. It will restore earned benefits to these heroes and ensure that their families will receive a pension upon their premature death. It will also implement the recommendations of the IOM's Agent Orange committee. This is not a gift. It is not welfare. It is an earned benefit bought and paid for with their health and their lives. I urge this Committee to favorably report H.R. 2254 with a strong recommendation that it be sent to the full House for expedited passage. Again thank you for the opportunity to speak with you today. It is a great personal honor both to appear before you and to represent the Navy heroes of the Vietnam War. God bless our veterans and God bless the United States of America.

**Prepared Statement of John Paul Rossie, Executive Director,
Blue Water Navy Vietnam Veterans Association**

The Problem of H.R. 2254

H.R. 2254 is being held in Committee, even though it has 256 cosponsors within the House. That means it has a pretty good chance of passing the House by a substantial margin. And yet, it sits.

This situation makes me question this government's willingness to keep its promises to all its veterans. The commitment of a nation to provide care to its veterans was clearly expressed by Abraham Lincoln when he prayed for people to do the right thing, "... to care for him who shall have borne the battle and for his widow and his orphan" More recently, we have heard pledges by members of this legislature to support Vietnam veterans. The last time I saw its language, H.R. 2254 would recognize certain individuals who show symptoms of contamination by herbicides used in Vietnam if they served offshore of Vietnam or were in the vicinity of Vietnam. There was conjecture that it ought to cover military personnel not in the local area of Vietnam, but who handled the herbicide containers and show symptoms of contamination.

The Need for Proof

We hear rumors that one thing delaying passage of H.R. 2254 is a need for proof that these individuals were contaminated by herbicides. In the requirement of demanding that proof, Congress is holding these individuals to a much higher standard than some other military personnel. If a member of the Armed Forces can show that they actually stood on the soil of the Vietnam homeland, they are granted their medical and compensation benefits under a concept of "presumptive exposure." Presumption of exposure does not require proof of any sort, short of documentation verifying a physical presence, for even the shortest amount of time, on the land mass of Vietnam. They are not questioned on the possible mode of transport that caused their exposure, nor are they required to prove their physical location while on Vietnamese soil. They are not asked about or tested for dosage of exposure. They need only present with symptoms as specified by the Department of Veterans Affairs (DVA). Yet their symptoms are identical to the symptoms of personnel who did not have a physical presence upon the land mass of Vietnam. Here we see a very clear instance of comparing elements that both walk like a duck and quack like a duck, but are denied a rational conclusion that they both are ducks. Denial of this commonality is the first hint that something is terribly wrong.

The Statistical Analysis

In a classic manner of rationalizing, there comes the fatal slide to the analysis of numbers. There are those who want to see perfect columns of numbers showing several enumerable facts:

- How many people are we talking about that will be impacted by the passage of H.R. 2254?
- How many dollars are associated with compensating each individual?
- How long a time will these payments be made?
- What are the exact parameters to qualify for H.R. 2254 benefits?

But actually, we are not really talking about numbers. We are talking about human beings and the quality life and death of those people. We are talking about providing a basic dignity in dying. We are talking about how we can provide comfort

in the final days of human beings who are dying of unnatural causes directly related to their duties in the Armed Forces during the Vietnam War.

Do I mean to say that these numerical values are not needed for a decision to be made? Yes, categorically. The issue of H.R. 2254 is about humanitarian principles. Does it matter if we are talking about 0.01 percent of the total U.S. population or 1 percent of the total U.S. population? Absolutely not. Regardless of the number of people involved, we are still talking about the death of human beings; human beings who just happened to swear an oath to fight for this country so that our principles of free speech and peaceful assembly, exactly like what we are doing with this Committee Hearing, can go forward without fear of “black-booted thugs” bursting in to shoot, arrest or even just harass us.

The willingness to give one’s life for one’s country is not the same as volunteering to be a guinea pig for Chemical Warfare. The symptoms we are talking about are the result of Chemical Warfare. The herbicides were developed to kill plant life, but their additional consequence was that they contaminated our own soldiers and sailors. Please call it like it is. We are acknowledging that this government may have been completely ignorant of the impact on our own soldiers. But those consequences are taking the lives of our veterans, and something needs to be done about it right now. This legislative body needs to take ownership of this problem and fix it.

The Inevitable

All of us are going to die at some point in time. But we generally assume it will be by natural causes. Or it could be by accident, but we still picture that as a fairly quick process. Our military personnel contaminated by chemical agents are dying of unnatural causes with slow and painful deaths. The average life span of a non-veteran male in the United States is something near 79 years. The average life span of a Vietnam veteran is about 66 years. So in addition to having defended this country and dying a painful, gruesome death because of it, we are giving up, on average, about 13 years of our lives.

We have set ourselves up to be the policemen of the world. We occasionally come across situations where a foreign government uses Chemical Weapons on its own people, and we howl and are the first to shout and point a finger at an atrocious violation of human rights. We get righteously indignant. Even though we did not intend it, the veterans of Vietnam are dying horrible, prolonged deaths like all other victims of manmade Chemical Weapons. What our soldiers and sailors are dying of looks very similar to what other people go through when dying of chemical poisoning. Both of these situations look like ducks, quack like ducks, smell like ducks. How much more evidence do we need to conclude that, by golly, we’ve got two ducks here?

Pointing fingers and assigning blame is not what this is about. It is about recognizing a problem and fixing it. This Committee can do something right now to address the current problems that still exist for some Vietnam veterans. That is all we are asking you to do. Act now, before we are all dead.

In putting our estimates of how many veterans will likely be impacted and what the potential cost of this bill could be for new claims of livings veterans, we did work through the numbers, very carefully. And those numbers are presented here in the Appendix. In A-1, we have an analysis of the number of troops most likely involved in various elements of the Vietnam War. The data attempts to count the number of military personnel in the “off shore” regions and those assigned to Thailand, Cambodia and Laos. The two organizations that jointly authored that paper are clearly identified. The analysis might contain refutable numbers, or someone might argue that it is totally wrong whether it is or not. However, all sources were traced as far back to the original sources as possible.

Appendix A-2 provides a screen capture simulation of a lengthy and complicated spreadsheet that shows the associated costs of H.R. 2254 as regards new claims for presumptive exposure. The screen shot shows the total project cost, which occurs in the year 2020, 10 years from now. ***After that date, we postulate that no significant number of this class of veterans will be alive.*** The full spreadsheet is large and needs to be reviewed in full on the Internet at <http://bluewaternavy.org/spreadsheet%202254.htm>. Since several factors in a complete cost analysis are variable, that Internet location includes an MS Excel spreadsheet that can be downloaded to a viewer’s computer. The user can change very key data points to see the effects on cost. Parameters available to change include:

- Total number of Blue Water Navy (BWN) veterans who served
- Percent still alive
- Percent who will seek/not seek benefits
- Percent who will receive 100 percent disability rating
- Percent who will receive 40 percent disability rating

- Monthly & Annual Cost of BWN veterans receiving 100 percent disability
- Monthly & Annual Cost of BWN veterans receiving 40 percent disability

I provided this tool so everyone could put in their own range of numbers for several components that make up the final cost. You should download this spreadsheet and manipulate it because it is very educational and instructive and hopefully provides a new perspective on estimating these costs.

Uncertainty

But I have already stated we are not playing the numbers game. No matter what number is chosen, another number can be given to challenge the first. And do you realize who you are playing number games with? Certainly not the American public. Certainly not the veterans who are asking for your help. In this case, it is with an agency that absolutely cannot provide “the real and exact number” of any basic head count related to the Vietnam War. Every number they have to work with started as an after-the-fact estimate by the Department of Defense. “The real numbers” do not exist. What you are getting from the DVA are estimates and extrapolations that have appeared to solidify over the years and tend to be taken as concrete and true. In some cases, those estimates are probably very close to reality. In other cases, not so much. The basic numbers of participants in our Vietnam War were estimated quite some time ago, and over the years they have become accepted Urban Myth. But they are no more solid or certain than that.

Where is my source for such an outlandish statement? Well, beyond common sense, and a knowledge of history, and the experience of being there and noting how records were kept, it is a bit of wisdom passed on to me by the Department of Veterans Affairs, Office of Policy & Planning some time ago. It has also been reported to me by the National Archives Electronic Records Division and the Library of Congress. I will not release personal information on the sources involved in my conversation. But if you get through all the parts of my presentation and still have doubts about my honesty, I have to suspect you have not read this with an open mind.

I will not be guilty of placing a dollar value on the men and women that I speak for. I will let that be your job. My main concern is to help you realize that this is a very clear situation with a very simple solution. These men are sick. They are disabled by illness on the list of presumptive diseases for dioxin poisoning. If you took a soldier who served on land that is dioxin-sick, and a sailor who served offshore that is dioxin-sick and set them in a room together, no doctor would see the difference. They both look like ducks. They both quack like ducks. They both smell and waddle like ducks. My guess is that they are both ducks.

But I would like to take the pressure off. I am not even asking you to declare them as ducks. That can come later; history can sort that out. If you are so obviously uncomfortable with identifying and labeling the parts of these ducks, then do not worry about that. Let someone else worry about putting their neck in that imaginary noose. But these poor ducks have spent the past 40 years paying for their own medical care, and now they are in desperate need. They can not afford more medical care. They can not afford to eat well or even pay their rent. Many have been forced to give up their homes for much smaller accommodations. They can not provide for their families. And they are just damned tired of trying to deal with the DVA. They are tired of that illusive false hope that sometimes dangles in their faces.

No one can tell you that our diseases were absolutely not caused by dioxin. We were often no further than a couple hundred yards from the men who served on land. Isn't that a strange coincidence that we both have the identical problems? No one can tell you that the amount of Agent Orange dumped into, sprayed onto, blown by the wind or washed into the South China Sea by run-off water was not enough to transit 80 to 100 miles from the shoreline of Vietnam to the constantly moving location of Yankee Station—possibly via the microlayers that can travel below the surface for extreme distances. It is medically and scientifically impossible for anyone to make a definitive statement that the diseases of offshore veterans, or veterans from other areas, were not caused by the dioxin content within Agent Orange.

We believe that the Department of Veterans Affairs, by their own admission, is using numbers inappropriately. They are using what we believe to be inflated estimates as a scare tactic, and we fear you have bought into it. They have over-inflated the number of veterans one can rationally project to have been in Vietnam, or offshore Vietnam, or in the vicinity of Vietnam. They have over-inflated the number of veterans who are probably alive today. And they have projected their response to compensation claims to a level that far exceeds their past trends. America can find hundreds of millions, and even trillions, of dollars for far less worthy enterprises. And yet we cannot afford to care for damages of war to our own military. We are watching this happen to us, the Vietnam veterans. We are watching this

happen to our children, who fought the Gulf War and served in EOF/IOF and Afghanistan. We have watched both the DVA and our legislators use number games to save trivial dollars at the expense of making this country morally bankrupt. Where is the value, in that scenario?

The End Game

Will our government provide a small percentage of the population with the pittance it takes to live out the next six to 10 years? With that, we can die in less miserable conditions and can leave this world knowing the country we served afforded this dignity in our death. They had already promised to soothe us and our families in our final hours. Can we be comfortable leaving our families strapped with our medical bill, or in poverty housing? No one is asking for this assistance except those who can prove an Agent Orange-based disability and we are asking for no more than other veterans of the Vietnam War are given.

Can we expect H.R. 2254 to become law before we die? If not, then please just tell us. We are mature enough to take a negative answer—after all, we were ready to die for you and this government 40 years ago. And we have been living and dying with false promises since then. Just tell us so we can have absolute certainty of how this country and its leaders really value us. But we also ask that you stop delaying and lying to us while you comfortably sit back and wait for us to die. In a very few years, we will not be alive, and you will never have to step forward and honestly deal with this problem. It will be thrown onto the bone pile the way many other problems are currently being handled. And you wonder why the approval rating of your jobs and of this administration's actions have fallen to new low points!

We are asking you to do something that will allow us to die with dignity. Do not keep playing this game of delay, deny, until we die. And do not keep dishing out false hope.

Please, if you have already decided you will never fund H.R. 2254 and S. 1939, just tell us to go away. We will stop wasting your time and our energy, and we will find some alternative to living and dying with our illnesses and our frustration.

Appendix A-1
Military Personnel in Vietnam



Research Provided by Members of
the Veterans Association of Sailors of
the Vietnam War and Blue Water
Navy Vietnam Veterans Association



Statistics are valid as of 12/16/2009

Potential Veterans Affected by the Agent Orange Act of 2009

Total Vietnam Era Veterans receiving DVA compensation – 2008 1,015,410¹

Not all of these Vietnam War Veterans are receiving compensation from the effects of Agent Orange

Vietnam Era Veterans receiving compensation for Agent Orange diseases of 99,226 requests	7,520 ²
Percentage of Vietnam War Veterans receiving compensation for AO exposure of 99,226 requests	7.6% ³
Percentage of Vietnam War Veterans receiving 10% disability for any condition (\$123.00/mo)	27.0% ⁴
Percentage of Vietnam War Veterans receiving 100% disability for any condition (\$2,673.00/mo)	8.0% ⁴

DVA has reported that based on DOD records at the end of the War.

Total Veterans deployed to Southeast Asia	ALL RECEIVED VSM / AFEM ⁵	3,403,100 ⁶
Total "in-country" Vietnam War Veterans	(boots on the ground)	2,594,000 ⁷
Total "off-shore" Vietnam War Veterans	(Blue Water Navy)	514,300 ⁸
Total "T.L.C." Vietnam War Veterans	(Thailand, Laos, Cambodia)	294,800 ⁹

Current estimate of "In-Country" Vietnam War Veterans still living	(less than) 850,000 ¹⁰
Current estimate of Vietnam Veteran that died between 2000 and 2007	490,135 ¹¹

The projected estimates of the "off-shore" and "TLC" Vietnam War Veterans still living was calculated at the same percentage ratio as the "in-country" Veterans. (32.8%)

Potential number of "off-shore" Vietnam War Veterans still living	168,525
Potential number of "T.L.C." Vietnam War Veterans still living	96,600

Potential number of Vietnam Era Veterans still alive that may be eligible to file Agent Orange Claims once The Agent Orange Equity of 2009 (HR2254 / S1939) is enacted, and only if diagnosed with a presumptive disease. Not all will have been or will be diagnosed with a presumptive disease and not all eligible Veterans will file a claim.

265,125

¹ DVA's Publication "America's Wars – 2008"

² Agent Orange: Statistical Update, March 2000, VA Office of Public Affairs

³ "Agent Orange: Statistical Update," March 2000, VA Office of Public Affairs, Media Relations Office (80-F)

⁴ Presentation to the Veterans Disability Compensation Commission, September 14, 2006 By Adm. P. J. Dunne

⁵ Vietnam Service Medal or Armed Forces Expeditionary Medal-Vietnam-Must have served in the Vietnam War Combat Zone.

⁶ Department of Defense estimate

⁷ Pentagon, June 4, 1993

⁸ VFW Magazine, January 2003

⁹ DOD number of total deployed to Southeast Asia, minus "in-country" and "off-shore"

¹⁰ Vietnam Veterans of America Association

¹¹ Chicago Tribune based on Statistics supplied by DVA

Appendix A-2
Spreadsheet of Cost (Screen capture simulation)
Estimates for H.R.-2254: With User-Defined Parameters

TOTAL ANNUAL AND AGGREGATE COST OF THE AGENT ORANGE ACT OF 2009		Year	2020
Total number of Blue Water Navy (BWN) Veterans who served (1*)	514,300		
Total number of personnel who served in Thailand, Cambodia, and Laos (1*)	294,800		
Number of BWN and TLC veterans who served during Vietnam War	809,100		
% still alive	33.0%		
Total living veterans eligible for benefits under AO Act of 2009 at year's end (3*)	267,003	2009	6,898
% who will not seek benefits (4*)	70.0%		
% who will seek benefits	30.0%		
BWN veterans forecasted to file for benefits			2,069
% of claims denied by the VA (5*)	60.0%		1,242
Number of processed claims	40.0%		828
% who will receive 100% disability rating (6*)	12.0%		
Veterans who will receive 100% disability rating			99
% who will receive 40% disability rating	88.0%		
Veterans who will receive 40% disability rat- ing			728
Monthly & Annual Cost of BWN veterans re- ceiving 100% disability (7*)	\$2,823	\$33,876	\$3,364,894
Monthly & Annual Cost of BWN veterans re- ceiving 40% disability	\$601	\$7,212	\$5,253,350
ANNUAL COST OF AGENT ORANGE ACT OF 2009			\$8,616,244
CUMULATIVE COST OF AGENT ORANGE ACT OF 2009			\$2,124,765,333
Average cost for 1 year per BWN veteran (8*)			\$10,412
Daily BWN Vietnam Veteran deaths (9*)	39	14,235	22,381
Total Cumulative BWN Vietnam Veterans			268,251
Annual Mortality Rate for BWN Vietnam Veterans (10*)			49.0%
Annual Increase in Mortality Rate			2.5%
Average Age at Death for Vietnam Veterans	66		

**Prepared Statement of Vivianne Cisneros Wersel, Au.D., Chair,
Government Relations Committee, Gold Star Wives of America, Inc.**

Mr. Chairmen and Members of the House Committee on Veterans' Affairs, I am pleased to be here today to testify on behalf of Gold Star Wives on the health effects of the Vietnam War and its aftermath for our Nation's surviving spouses. My name is Vivianne Wersel, Chair of the Gold Star Wives' Government Relations Committee. I am the widow of Lt. Col. Richard Wersel, Jr., USMC, who died suddenly on February 4, 2005, one week after returning from his second tour of duty in Iraq. I am also the daughter of Colonel Philip C. Cisneros, USMC (Retired) who fought in the Chosin Reservoir in Korea and served three tours of duty in Vietnam.

Gold Star Wives of America, Incorporated (GSW), founded in 1945, is a Congressionally Chartered organization of spouses of military members who died while serving on active duty or as a result of a service-connected disability. GSW is an all-volunteer organization. We could begin with no better advocate than Mrs. Eleanor Roosevelt, at the time newly widowed, who helped make Gold Star Wives a truly "national" organization. Mrs. Roosevelt was an original signer of our Certificate of Incorporation as a member of our Board of Directors. Our current members are widows and widowers of military members who served during World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in both Iraq and Afghanistan and every period in between.

I will start with our primary message to you today—nearly 40 years since the last American servicemembers left Vietnam we are still dealing with the repercussions. We cannot forget the importance of communication to the impacted community, including the surviving spouses of that era.

There is no question of the magnitude of the problem that this Nation must continue to face. For nearly 20 years, the Department of Veterans Affairs (VA) has provided disability benefits to Vietnam veterans who suffer from certain illnesses causally linked to Agent Orange exposure. With the addition of two new and one expanded Agent Orange presumptive diseases, the VA will be automatically awarding disabilities for 14 different conditions. We are heartened by the restarting of the National Vietnam Veterans Longitudinal Study as it is very clear that our knowledge is not yet complete on the long-term health consequences of those who served in the Vietnam War. For over 2.1 million current Vietnam veterans, this has been a long and often arduous road. I can't help but think that what we learn here will lead us to better care for all of America's veterans, their families and survivors, including those engaged in the current wars/conflicts.

A common theme that the membership of Gold Star Wives encounters, whether from the new, young surviving spouses of the current wars or those survivors from earlier conflicts, is the lack of information—the lack of the government reaching out to them to alert them to changes in benefits and compensation that they may be eligible to receive. Many were never informed of their benefits initially and many still are not aware of their benefits. So while it is wonderful for the scientific community to gain these valuable insights, the next crucial step is to assure that those who have been harmed as a result of exposure to harsh chemicals, can adequately understand what they must do to improve the quality of their health and lives to the extent that that can occur. VA outreach to survivors must be drastically improved.

A widow in Florida has an adult son with spina bifida. Her son is relatively independent yet he still needs care. Since the loss of her husband, the widow now bears the full burden of caring for her adult son.

For many years caregivers provided for their spouses who were less than 100% disabled and these widows were not eligible for DIC when their spouses died. The caregiver's quality of life was compromised as well as their own health. The many spouses who cared for these dedicated servicemembers were forgotten. Many spent their life savings for medical expenses. Spouses were forced to give up careers because their disabled husbands needed ongoing care. These families have survived after their husband's death however the pain of their experience is still vivid. Therefore it is important to further investigate the results of the affects of the deadly toxins used in Vietnam as well as to identify the servicemembers, their spouses or surviving spouses. Not everyone has a connection with the military or the VA.

My uncle served his country and died of ALS in January 2005. My aunt was not married to him during his military service and was unaware of the change in the VA policy to include ALS as a presumptive disability. This benefit made a difference to her quality of life yet she never would have known if I had not made a point of sharing this information. We are certain that there are many other surviving spouses who have yet to be identified as beneficiaries. We as a grateful nation have

an ethical role to reach out to better identify those veterans and survivors who qualify for compensation.

We do not want new members in our organization because of the requirement for entry—the loss of a loved one—but we are protective of those who eventually will join us, as well as for those surviving spouses who suffered right along with the veteran during these last 40 years. They need to be given some peace of mind about why life was so radically different for so long after their spouse returned from Vietnam whether it was PTSD or bearing a child with a neural tube defect or sadder yet left barren.

We don't yet know how many generations will be affected by Agent Orange. The children and grandchildren of Vietnam veterans are suffering the after-effects. The results of the longitudinal study should reveal the adverse effects for future generations. We have concerns for the veterans and their survivors who were never in the VA system, but became ill and died. Many veterans may have died years ago of conditions just now being recognized as caused by Agent Orange. How are we going to locate and notify those survivors? Who takes this lead? The VA must take the lead in outreach to these servicemembers and survivors. In concert with Veterans, Military and survivor organizations, many more deserving and qualified beneficiaries must be found.

Service to this Nation deserves life-long respect and care, certainly to the veteran, but to the veteran's family as well, even when that veteran is no longer alive. Not only did returning Vietnam veterans experience adverse encounters with an ungrateful nation, but they also had to return to an uncaring government that sent them to war, perhaps even against their will because of the draft. The Vietnam veteran did battle *for* our country and now has to do battle *with* VA bureaucracy and rules to obtain the benefits he deserves and has more than earned. In many instances, the surviving spouse must continue to fight for the benefits the veteran earned. It is our responsibility as a nation to honor those veterans and their survivors.

Please continue with the longitudinal study, look at all independent variables, including interviewing the deceased spouses. Simply stated by one of our members, "I just pray that no one else has to go through what Les went through, a very tortured, painful, long, anguished death. After his death I was burdened with medical bills, exhaustion, and a ruined career that I am still trying to repair." Results of the present longitudinal study may reveal new presumptive illnesses that not only affect the servicemembers but many generations thereafter.

In 1862 during the battle of Antietam, 23,000 men were killed in one day, which was the bloodiest single-day battle in our country's military history. In retrospect, the Vietnam War was the war whose casualties lingered over the longest period of time; it's the war that keeps on ticking. The VA needs to identify these late onset casualties to help minimize the suffering these families endure financially, emotionally and physically. Look deep in the histories of those who have died as well as their families.

We hope that the restart of the National Vietnam Veterans Longitudinal Study will continue to reveal data and information crucial to the optimal well being of our servicemembers and their families. It is imperative that a more aggressive outreach is implemented to identify veterans, spouses and survivors concerning any new presumptive illnesses developed as a result of this study.

No one said it more eloquently than President Lincoln in his second inaugural address:

"With malice toward none; with charity for all; with firmness in the right, as God gives us to see right, let us strive to finish the work we are in; to bind up the Nation's wounds, to care for him who has borne the battle, his widow and his orphan."

Thank you for this opportunity to testify. I will be elated to answer any questions you have.

**Prepared Statement of Joel Kupersmith, M.D., Chief Research and
Development Officer, Veterans Health Administration,
U.S. Department of Veterans Affairs**

Mr. Chairman, Mr. Ranking Member, and Members of the Committee: Thank you for the opportunity to appear today to discuss the Department of Veterans Affairs' (VA) progress in conducting the National Vietnam Veterans Longitudinal Study (NVVLS) and the illnesses associated with exposure to Agent Orange. I am accom-

panied by Victoria Anne Cassano, MD, MPH, Director, Radiation and Physical Exposures; and Acting Director, Environmental Agents Service, VHA. My testimony today will discuss the history of the NVVLS, VA's current plans for a comprehensive, longitudinal study of Vietnam Veterans, other research relevant to Vietnam Veterans, and our health care programs specifically tailored to the needs of Vietnam Veterans.

History of the National Vietnam Veterans Longitudinal Study

In 1983, Congress mandated that VA conduct a study on post-war psychological problems among Vietnam Veterans. VA contracted with an external entity, the Research Triangle Institute, to conduct the National Vietnam Veterans Readjustment Study (NVVRS). The study, completed in 1988, provided an extensive report of disabilities, including post-traumatic stress disorder (PTSD), in Vietnam-era Veterans, and is considered to be a landmark study of PTSD and its consequences in Vietnam Veterans. Based on the diagnostic approach used in the study, it was determined that 15 percent of male Vietnam Veterans experienced PTSD within the previous 6 months and an estimated 31 percent would experience PTSD during their lifetime. Prevalence rates for PTSD in female Vietnam Veterans were similar but somewhat lower. Subsequent reanalysis of the original NVVRS data by other scientists has estimated a somewhat lower prevalence of PTSD that is more in line with other studies of PTSD in Vietnam Veterans.

In 2000, Congress passed and the President signed the Veterans Benefits and Health Care Improvement Act of 2000, which became Public Law (P.L.) 106-419. Section 212 of this legislation directed VA to contract for a follow-up study of Vietnam Veterans in the original 1988 NVVRS. In 2001, VA entered into a contract with the same contractor for a follow-up called the National Vietnam Veterans Longitudinal Study (NVVLS). However, delays, escalating costs, and concerns about contracting practices prompted suspension of the study and cancellation of the contract before data collection began. A VA Office of Inspector General (OIG) audit report, released September 30, 2005, confirmed ineffective planning, contracting, and project management.

In 2008, the Senate Appropriations Committee included a requirement in Senate Report 110-428 directing VA to fulfill the requirements of section 212 of P.L. 106-419. In January 2009, VA informed the Chairs and Ranking Members of the House and Senate Veterans' Affairs and Appropriations Committees of concerns that the NVVLS approach would not adequately or substantively address questions about the mental or physical health status of the Vietnam Veteran population or about the course and consequence of PTSD. VA had, in the interim, initiated a broad portfolio of scientifically rigorous studies dedicated to addressing the needs of the Vietnam Veteran population and offered two of these as alternatives to restarting the NVVLS. Specifically the Department has funded several major research efforts, including a longitudinal follow-up study entitled, "A Twin Study of the Course and Consequences of Post Traumatic Stress Disorder (PTSD) in the Vietnam Era Veterans," based upon the well-studied Vietnam Era Twins Registry (VET-R), together with a second study, "Determining the Physical and Mental Health Status of Women Vietnam Veterans."

The House Committee on Veterans' Affairs concluded in June 2009 that these two studies did not adequately address the law and directed that NVVLS be completed. In September 2009, the Secretary of Veterans Affairs announced that the agency planned to award a contract to an external entity to conduct the NVVLS.

Current Plans for NVVLS

VA understands that Veterans and Congress are still concerned about the long-term effects of military service in Vietnam; VA shares that concern as well. This is why VA continues to support programs and efforts addressing the needs of the Vietnam Veteran population. VA also has reinstituted the process to contract for the completion of NVVLS, paying close attention to prior OIG recommendations and the intent of P.L. 106-419. VA's Office of Research and Development (ORD) is managing the project and has completed a number of necessary steps.

Specifically, in September 2009, VA convened a scientific panel and other experts (legal, administrative and contracting) as part of an Integrated Project Team (IPT) to develop requirements for the NVVLS. The Scientific Panel consisted of subject matter experts from within and outside of VA. This Panel was asked to establish the scientific requirements and propose a valid approach to serve as the basis for the contract. They identified several challenges to reopening the NVVLS:

- The data from the initial contractor regarding NVVRS must be transferred safely and securely to the new contractor for NVVLS.

- There may be difficulties in getting the original cohort of Veterans to participate in the new NVVLS. Of those not already enrolled in the VA system, it is not known how many would be located and agree to participate in a new study, or even how many are still alive. Thus it is unclear if the sample size will be large enough to yield statistically significant findings, particularly for questions involving subgroups.
- Methods for diagnosing PTSD have evolved over the 25 years since the NVVRS. The design of the NVVLS will need to strike a balance between repeating methodologies using in NVVRS, for the sake of longitudinal consistency, and incorporation of new diagnostic strategies for contemporary validity.
- The NVVRS was not designed to accommodate a follow-up study and there is a potential for statistical bias that the contractor will need to consider.

As part of re-opening the NVVLS, the IPT also developed a Performance Work Statement and Acquisition Package during 2009. In early March 2010, the IPT forwarded the Package to the VA Contract Review Board. This Package contains:

- A Performance Work Statement, which describes the background of NVVLS, public law mandates, the study objectives, the specific mandatory tasks (organized by study phase) and associated deliverables, and VA security and data use and ownership requirements;
- An Acquisition Plan, which describes the statement of need, schedule constraints, current estimated cost, desired capability of offers, risks, plan of action, and milestones. The plan of action also describes the evaluation factors for source selection;
- An Independent Government Cost Estimate, which describes the methodology and assumptions in calculating the best estimate of the cost of the contract;
- A Market Research Report, which describes the outcome of market analysis, including a request for information along with online searches for capabilities of potential offers under social-economic considerations; and
- A certificate of a potential Contract Officer Technical Representative (COTR).

Once the Acquisition Package has been approved, VA will solicit bids and evaluate proposals; we expect this will be completed this summer. VA will then award the contract and begin the study in the early fall. VA has established a project management structure to ensure: the project reaches its objectives; a COTR in ORD will monitor the contractor's performance and ensure that the contractor adheres to study performance requirements, cost, reporting schedule, and timeliness; and reports any unexpected events in the course of the study. The IPT has determined milestones for the study and the COTR will use performance metrics to monitor progress.

Between 2011 and 2013, the awarded contractor will obtain Institutional Review Board (IRB) and Office of Management and Budget (OMB) approvals for the project and initiate the study under VA monitoring. By 2014, the data should be available for analysis and we anticipate the results will be available shortly thereafter for publication in a scientific journal.

The new NVVLS will consist of the following four phases:

- *Feasibility Phase:* Establish how many individuals from the original National Vietnam Veterans Readjustment Study (NVVRS) cohort are available and potentially willing to participate in the NVVLS;
- *Start-Up Phase:* Prepare the assessment and data collection materials, finalize protocol and obtain IRB and OMB approval.
- *Implementation Phase:* Recruit and enroll participants, conduct assessments on all participants.
- *Close-Out Phase:* Analyze data, prepare final reports, and deliver data to VA.

VA is committed to the success of the NVVLS and will continue to keep Congress apprised of any significant developments.

Other Research on Vietnam Veterans

The U.S. Air Force made a commitment to Congress and the White House in 1979 to conduct an epidemiologic study of the military personnel that were likely to have been the most highly exposed U.S. Servicemembers to Agent Orange herbicide in Vietnam, in Operation Ranch Hand missions. The "Ranch Hand" study's assets include an electronic database and biospecimens such as serum, urine, adipose tissue and semen. These have been maintained and managed by the Medical Follow-Up Agency of the Institute of Medicine of the National Academies (IOM) as directed by P.L. 110-389, the Veterans' Benefits Improvement Act of 2008. This act authorizes IOM during fiscal years 2009 through 2012 to conduct additional research on the assets to develop a better understanding of the health determinants and wellness

promotion among Veterans. The law also requires an IOM report to Congress assessing the feasibility and advisability of conducting additional research on such assets after the end of fiscal year 2012. To accomplish this goal, VA is contracting with IOM; to date, VA has met with IOM and has enlisted the assistance of VA's Office of General Counsel and a contracting specialist. Ultimately, funds will be transferred from VA to the U.S. Air Force for the maintenance of the biospecimens using a Military Interdepartmental Purchase Request.

VA's Health Care and Benefits Programs for Vietnam Veterans

In addition to its research portfolio for Vietnam Veterans, VA has a number of health care programs specifically designed for this population. The most notable example of health effects related to military service from Vietnam are the health effects associated with exposure to herbicides such as "Agent Orange." During the Vietnam War, the U.S. military used more than 19 million gallons of various herbicides for defoliation and crop destruction in the Republic of Vietnam. Veterans who served in Vietnam anytime during the period beginning January 9, 1962, and ending on May 7, 1975, are presumed to have been exposed to herbicides.

VA established the Agent Orange Registry to track the special health concerns of Veterans who may have been exposed to Agent Orange during their military service. This program includes a medical exam that is comprehensive (including exposure and medical histories, laboratory tests, and a physical exam). A VA health professional discusses the results with the Veteran in a face-to-face consultation and a follow-up letter. The exam is cost-free for Veterans and does not require enrollment in VA health care or VA's benefits programs. Veterans who served in Vietnam or other areas where the herbicide Agent Orange was sprayed are eligible for the Agent Orange Registry examination. Veterans should ask to speak to their Environmental Health Coordinator or Patient Care Advocate at their local VA medical center for information about participating in an Agent Orange Registry health exam. VA also offers an array of resources to providers to inform them of health care concerns and treatment approaches related to Agent Orange exposure. We are currently in the process of updating the Veterans and Agent Orange Veterans Health Initiative (VHI). Now called "Caring for Vietnam Veterans," this program will cover a range of issues including Agent Orange, infectious diseases, post-traumatic stress disorder (PTSD) and other psychological outcomes, as well as reproductive outcomes specifically related to the Vietnam War.

On March 25, 2010, VA published a proposed regulation to establish presumptions of service connection between exposure to herbicides in Vietnam anytime during the period beginning January 9, 1962, and ending on May 7, 1975, and Parkinson's disease, ischemic heart disease (IHD), and all B-Cell leukemias (which include Chronic Lymphocytic Leukemia, previously service connected, and hairy cell leukemia). This decision was based on an analysis of the findings from the Institute of Medicine's seventh biennial update, "Veterans and Agent Orange: Update 2008." As a result of this decision, an estimated 86,069 disability claimants who were previously denied benefits for one of those conditions will be eligible to receive retroactive payments for the new presumptive conditions in 2010. An estimated 32,606 Veterans who currently receive compensation for other service-connected conditions will become eligible for prospective benefits based on the new presumptions in 2010, which may increase their disability payments. An estimated 28,934 and 10,416 potential accessions are also expected in the same year for Veterans and survivors, respectively. VA estimates that the total impact on health care costs for this new determination will be \$236 million in fiscal year (FY) 2010, \$165 million in FY 2011, and \$171 million in FY 2012. VA is requesting a supplemental 2010 appropriation of \$13.4 billion to provide for the increased disability compensation and survivor benefits.

The new rule will bring the number of categories of illness presumed to be associated with herbicide exposure to 14 and significantly expand the current leukemia definition to include a much broader range of chronic B-cell leukemias beyond Chronic Lymphocytic Leukemia previously recognized by VA. VA has previously recognized a number of other illnesses as presumptively service connected for exposure to herbicides during the Vietnam War, including: AL Amyloidosis, Acute and Subacute Transient Peripheral Neuropathy, Chloracne or other Acneform Diseases consistent with Chloracne, Chronic Lymphocytic Leukemia, Diabetes Mellitus (Type 2), Non-Hodgkin's Lymphoma, Porphyria Cutanea Tarda, Prostate Cancer, Respiratory Cancers, Soft Tissue Sarcoma (other than Osteosarcoma, Chondrosarcoma, Kaposi's sarcoma, or Mesothelioma), and spina bifida in the children of exposed veterans. Veterans whose service in Vietnam qualifies them for presumptive service connection of a medical condition do not have to prove they were exposed to Agent Orange to receive VA health care benefits related to Agent Orange exposure. VA op-

erates three War-Related Illness and Injury Study Centers (WRIISC) that provide clinical expertise for Veterans with deployment health concerns or difficult to diagnose illnesses. Any Veteran concerned about their exposure can seek a referral to a WRIISC from their primary care provider.

Conclusion

Mr. Chairman, Vietnam Veterans represent the largest portion of Veterans in terms of service era, and VA will continue to deliver them the quality health care and benefits they deserve. I thank you again for your support of our work in this area, and for the opportunity to appear before you today. I am now prepared to answer your questions.

Statement of Reserve Officers Association of the United States, and Reserve Enlisted Association

Introduction

Mr Chairman and Members of the Committee, ROA thanks Chairman Filner for the introduction of H.R. 2254, Agent Orange Equity Act of 2009, that includes blue-water sailors, and blue-sky airman for treatment of ailments relating to exposure to toxic herbicides, and the 256 House members who have cosponsored it. H.R. 2254 is intended to clarify the law so that every servicemember awarded the Vietnam Service medal, or who otherwise deployed to land, sea or air, in the Republic of Vietnam is fully covered by the comprehensive Agent Orange laws Congress passed in 1991.

A Personal Testimony

I am Captain Marshall Hanson, U.S. Naval Reserve (retired). I did two tours in the waters off Vietnam as a blue-water sailor. One tour in 1971 was under training orders as a college student, and the next just following my commissioning in 1972.



Marshall Hanson and daughter Sydney

Normally, I would be submitting written testimony strictly on behalf of the Reserve Officers Association and the Reserve Enlisted Association. ROA does have a resolution #11 that was passed in 2008 which talks to "Preserving Veteran Status and Benefits for Those Who Have Served in Theaters of Operations" that is based on the lack of available treatment for certain Vietnam Veterans, but for this one time I think I need to reflect on my personal experience.

In 1998, my youngest daughter was born with a cleft soft and hard palate, a condition that surprised my wife and me as we couldn't identify a reason for it at the time. Cleft palate is a condition in which the two plates of the skull that form the hard palate (roof of the mouth) are not completely joined, leaving a hole in the top of the mouth into the nasal passages. This condition has been found in offspring of veterans exposed to Agent Orange. From the characteristics of the cleft, the doctors assured us it was not genetic in the sense of family history. Luckily the correction to this condition was covered by private health insurance and personal copayments, and access to one of the world's best craniofacial surgery teams at Seattle Children's

Hospital. Today, she is a healthy smart-mouthed between, and dentists have to be informed that she ever had surgery.

With only 6 days in Da Nang, Vietnam, while awaiting transit to and from ships, I had always felt that I was lucky, figuring that I had little to no exposure to herbicides. Since moving to Washington, D.C. 11 years ago, I have had the chance to work with other Vietnam veterans who were not so lucky and had suffered from the cancers associated with Agent Orange. One, John Morrison, prematurely passed away with in the last few years, after decades of suffering from crippling ailments related to his exposure.

Then, I learned at age 57 that I have a heart condition that will require heart surgery in the fall of 2010. Was I exposed, and are herbicides the cause? Does my condition qualify as ischemic heart disease? These are questions yet to be asked and answered by my cardiologist. But this is yet another condition, without a family history correlation. Recent facts that I learned have caused me to wonder about a possible connection.

As the Committee is aware, American forces sprayed millions of gallons of Agent Orange and other defoliants over parts of Vietnam from 1961 to 1971. During "Operation Ranch Hand," U.S. forces sprayed about 20 million gallons of Agent Orange and other herbicides on southern and central Vietnam to deprive enemies of jungle cover. The ship that I was assigned to on my second tour was USS *Niagara Falls* (AFS-3), which was included on a short *presumption* of Agent Orange exposure list of offshore "blue water" naval vessels conducted operations on the inland "brown water" rivers and delta areas of Vietnam that was issued by the Department of Veteran Affairs.

I reported aboard the Niagara Falls in 1972, but the period of presumptive exposure is 1968. The Niagara Falls did similar types of assignments with cargo pickups anchored in the brown waters of Da Nang Harbor and replenishments off of Cam Ranh Bay and the mouth of the Mekong Delta. The Niagara Falls also steamed along the Vietnam coast resupplying Navy destroyers along the inshore gunline, and the aircraft carriers and support ships on Yankee Station to the North.

In addition to similar littoral water duty, the Niagara Falls like many blue water ships was exposed to herbicide runoff from Vietnam river basins. With 13 large river systems, Vietnam is considered to have a complex and dense river network with most of the large river systems linked. The Mekong River, alone, splits into nine arms, with all flowing down and emptying into the sea. Agent Orange is insoluble. It was carried whole into the swamps, down creeks into the rivers and down the rivers into the South China Sea.

It can also be noted in Figure One (see page 6) that herbicides were heavily sprayed along the coast. The Navy ships stationed of the coast were adrift in an herbicide soup, with runoff continuing to occur even after spraying ended in 1971.

Aboard Navy ships, potable water is produced by evaporative distillation of seawater. In distillation plants on ships seawater was usually fed into an evaporator where the water was boiled by a combination of heating and reduced pressure (vacuum). The vapor was condensed in the condenser from where it was pumped into the feed tanks.

As a result insoluble agents remained in the water. An Australian study focused on the evaporative distillation process that was used to produce potable water by Navy ships from surrounding estuarine waters. It was entitled *Co-Distillation of Agent Orange and other Persistent Organic Pollutants in Evaporative Water Distillation*, and found that "the main contaminant in Agent Orange was found at about 85 percent of the quantity observed in the control samples and co-distilled to a greater extent than any other PCDD/F investigated here." Sailors were being exposed to herbicides through their drinking water. The Australian study also was motivated by an Australian Veterans Administration report noted that veterans of the Royal Australian Navy (RAN) experienced higher mortality than other Australian Vietnam Veterans. Australia's largest naval commitment to the Vietnam War was the provision of destroyers, on rotation, to serve on the gunline—delivering naval gunfire support for allied ground forces.

Navy destroyers provided mobile battery support for troop actions in Vietnam. Located between one to two miles off the coast, they accurately fire 5 inch shells at a rate of 40 rounds per minute on targets at ranges beyond 14 nautical miles inland. This bombardment would go 24 hours a day, with ships firing thousands of rounds. These ships were close enough ashore that during the war, 29 gunline ships were hit by enemy shore artillery.

A question should be asked as to what happened to the remaining 15 percent? As kitchen chemistry demonstrates to anyone who cooks, an agent in the water when it is boiled migrates to the sides of a container. Boil an insoluble salt in a coffeepot, soon that insoluble salt coats the inside of the coffeepot. Through the dis-

tilling process, Agent Orange continued to percolate within the evaporators even after external exposure ceased because it coated the system. Every additional load of seawater taken into a Navy ship and then boiled added to the concentration of Agent Orange on the inside of the evaporators and condensers—continuing to contaminate potable water used on the ship.

Evaporators and condensers are not cleaned, unless the whole system is disassembled and re-installed. When undergoing Regular Overhaul (a 3-year cycle on destroyers) new evaporators and condensers are installed.

During the third year I was aboard USS *Niagara Falls*, the evaporator distillation had to be overhauled during the ship's cycle overhaul. Contaminant scale had built up requiring the system to be cleaned and parts to be replaced, finally removing any potential Agent Orange contaminate from the ship's drinking water system. If exposed, I not only was subject to particulates in 1971 and 1972, but may have also been exposed by contaminated ship's distilling systems until 1975, from sources earlier than 1971.

Unfortunately without the law being changed, the burden of proof is on me to convince the Veterans Administration that through my Vietnam service, I have been adversely affected by herbicides. There is an element of timing, and despite six days "feet on land" in Vietnam, there is no official documentation that I was there, although with luck I might get some confirmation from some classmates that I haven't seen for 38 years. My case is further complicated because of the nature of the statistical analysis used to determine a basis for presumption. And I am just one of hundreds of Reserve Officers Association and Reserve Enlisted Association members facing these challenges.

Health-wise I am told that I am not in a position to wait for the VA to process a delayed claim. With luck prior to required surgery, I will qualify for TRICARE as I am a retired Reservist who will turn 60 in September. While I have military health care to fall back on, most Vietnam Veterans don't have access to that as an option.

Conclusion

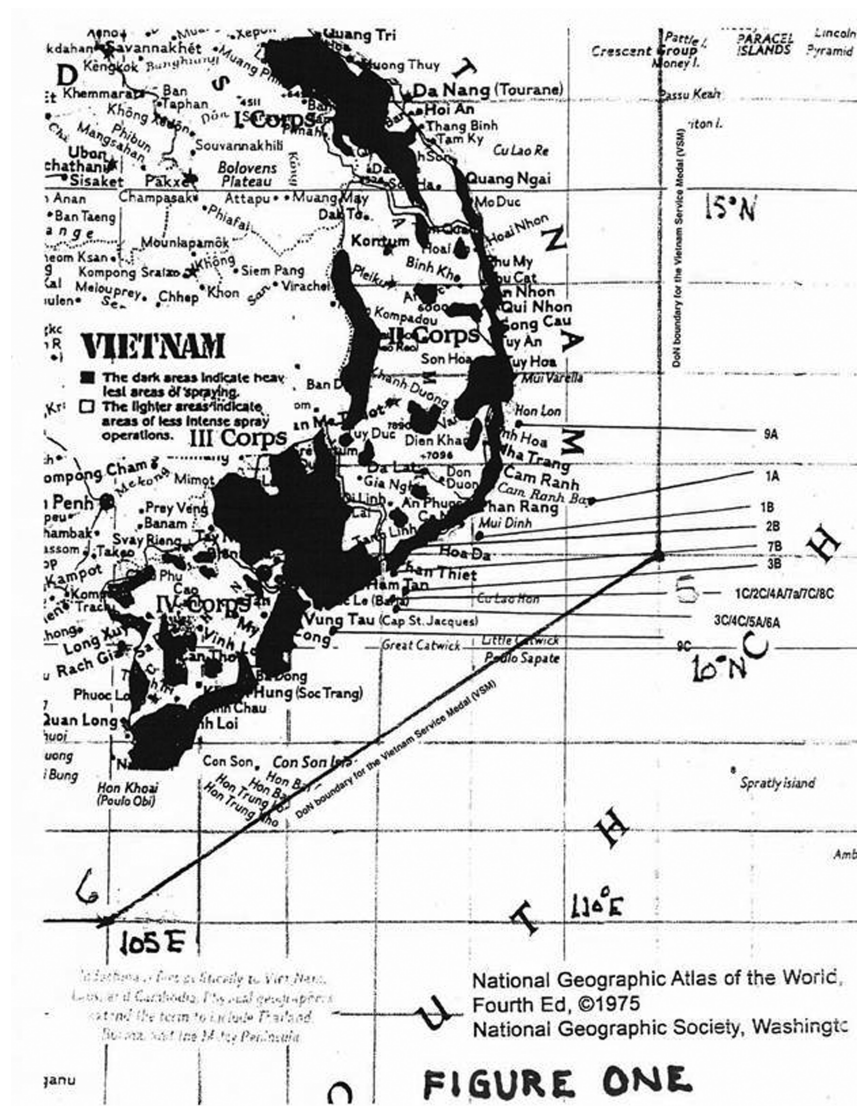
Thousands of Sailors served providing gunfire support aboard destroyers along the coast and on Yankee Station aircraft carriers providing air cover and bomb support over Vietnam. Navy veterans who were awarded the Vietnam Service Medal as a result of service in the waters offshore Vietnam (blue water vets) should be entitled to the same presumption of exposure to Agent Orange as veterans who set "foot on land" in Vietnam or did duty in brown water missions. As a result, many Navy veterans who served offshore and their survivors were granted disability or DIC benefits based on an Agent Orange-related disease.

Also overlooked are Air Force Airmen who were exposed to herbicides stored at staging airbases, and storage sites outside of Vietnam and in the airspace above. Many are suffering the same diseases as a result of exposure to the herbicide Agent Orange, and deserve Veteran health care, and disability benefits for their ailments, or care for survivors.

The Reserve Officer Association (ROA) and the Reserve Enlisted Association representing over 65 thousand members support expanding the presumptive coverage by the Department of Veterans Affairs.

But in addition ROA recognizes with Resolution 08-11 (see page seven) that exposures to chemicals, toxins and heavy metals can occur in any war and that these can be spread more widely by airborne drift or water-borne runoff than calculated computer models. It remains vitally important in any theater of contingency operations that individuals are recognized for their service and remain eligible for health benefits regardless of manner of exposure whether on land, sea, or in the air. Medical treatment of serving members as well as veterans needs to take precedence over determining statistical correlations.

Figure One follows: Spray Patterns of Herbicides in Vietnam.



Reserve Officers Association
Preserving Veteran Status and Benefits for Those Who Have
Served in Theaters of Operations. Resolution 08-11

WHEREAS, the Department of Veterans Affairs (VA) has proposed to amend its adjudication regulations regarding the definition of service in the Republic of Vietnam in regard to exposure to Agent Orange;

WHEREAS, the current definition of service in Vietnam includes service in the waters offshore and service in other locations if “conditions of service involved duty or visitation in the Republic of Vietnam”; and

WHEREAS, the VA wishes the definition “to include only service on land and on inland waterways” of the Republic of Vietnam; and

WHEREAS, thousands of Sailors served providing gunfire support aboard destroyers along the coast and on Yankee Station aircraft carriers providing air cover and bomb support over Vietnam; and

WHEREAS, thousands of Airmen stationed in Thailand, prepared aircraft and flew missions over Vietnam; and

WHEREAS, Marines and Soldiers fought in Laos and crossed into Cambodia; and

WHEREAS, distinguishing types of service in an theater of operations is a bad precedent, when “boots-on-the-ground” veterans are differentiated from all other Armed Forces participants, especially when this Nation is currently at war; and

WHEREAS, exposures to chemicals, toxins and heavy metals can be spread more widely by airborne drift or water-borne runoff than calculated patterns;

NOW THEREFORE BE IT RESOLVED, that the Reserve Officers Association of the United States, chartered by the Congress, urge the Congress, the Department of Defense and the Department of Veterans Affairs, to retain current definitions of service in any theater of operations ensuring that individuals are recognized for their service and remain eligible for health benefits regardless of manner of exposure whether on land, sea, or in the air.

Time Sensitive—submitted by ROA Headquarters Staff
Adopted by the ROA National Convention, June 28, 2008

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
May 10, 2010

Harvey V. Fineberg, M.D., Ph.D.
President
Institute of Medicine of the National Academies
500 Street, NW
Washington, DC 20001

Dear Harvey:

In reference to our full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

CW:ds

Institute of Medicine of the National Academies
Washington, DC.
17 June 2010

The Honorable Bob Filner
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Via fax: 202-225-2034/Attn: Debbie Smith

Dear Representative Filner:

Thank you for sending the follow-up hearing questions to the full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" held on 5 May 2010. Attached please find the answers to those questions. If we can be of further assistance, please contact Mary Paxton at 202-334-1731 or mpaxton@nas.edu.

Sincerely,

Harvey V. Fineberg, M.D., Ph.D.
President

**Responses to Questions Posed after
Hearing of the House Committee on Veterans' Affairs
Held on May 5, 2020**

Question 1: What will be your process in carrying out the Blue/Brown Water Navy study?

Response: In conducting the ongoing IOM study, Blue Water Navy Vietnam Veterans and Agent Orange Exposure, the IOM has followed its standard committee processes and procedures. After approval of the study by the National Research

Council Governing Board, the study is assigned to a division (in this case the Institute of Medicine), a board (the Board on the Health of Select Populations), and a study director. The study director is responsible for working with the Committee to develop a consensus report that addresses the Committee's charge. Specifically, the consensus committee was formed according to our standard practice as follows:

- Prospective members were suggested by individuals knowledgeable in the fields in which nominees are sought, including IOM, National Academy of Sciences, and National Academy of Engineering members, IOM Board Directors, members of the Board on the Health of Select Populations, and committee members from previous Veterans and Agent Orange committees. Over 80 people were screened as potential committee members. This committee was organized to reflect a range of technical expertise related to dioxin exposure and assessment. In addition to toxicologists, epidemiologists, and exposure assessors and modelers (both atmospheric and water), the Committee nominees included experts in desalination of water. None of the nominees had served on previous IOM Agent Orange studies.
- The Committee members were appointed by the Institute of Medicine with the approval of the President of the National Academy of Sciences.
- Before the appointments were finalized, the provisional committee members' names, affiliations, and short biographies were posted for public comment on the Academies' Web site for 20 days. All the Committee members participated in a bias and conflict of interest discussion at the first committee meeting to ascertain any potential conflicts of interest and to ensure that the Committee was properly balanced with regard to any biases.

The Committee has held the first of five meetings. At this first meeting, the Committee held an "information gathering" session that was open to the public. At the meeting, the Committee heard from three representatives of the Department of Veterans Affairs who provided the Committee with information on the need for the study, the charge to the Committee, an overview of the *Haas v. Peake* court case that eventually upheld the VA's determination that the presumption of herbicide exposure applies to veterans who served on land or inland waterways in Vietnam, but not to veterans who served only in offshore waters, and a discussion of the current process for reviewing Agent Orange claims by the VA Compensation and Pension Service. The Committee also heard from several veterans who had served in the blue or brown water Navy. The Committee also received numerous materials from Vietnam veterans, and all such materials have been included in the Committee's public access files. Following the open session, the Committee deliberated in closed session.

It is expected that a second information-gathering session will be held at the second committee meeting. That meeting, like the first one, will be announced on the Committee's Current Projects Web site and a notice will be sent to a list of interested veteran organizations and individual veterans. During its future meetings, the Committee will deliberate in closed session and prepare a draft report. The report will be based on what the Committee has learned at its open meetings, published literature and other resources, as deemed appropriate by the Committee members.

The draft report, once approved by the Committee, will undergo the National Academy of Sciences' report review process. This process entails the following:

- Prior to release, report is reviewed by individuals who are not involved in authoring the report and whose names are not revealed to the Committee or the study director during review.
- Reviewers are selected by the major unit responsible for the project, in consultation with the National Academy of Sciences' Report Review Committee.
- The review is overseen by a review monitor and/or coordinator.
- Each committee must respond to, but need not agree with, reviewer comments in a detailed "response to review" that is examined by the monitor and/or coordinator, who ensure that the report review criteria have been satisfied.
- The report may not be released to sponsor or the public until the chair of the Report Review Committee (or designee) signifies that the review process has been satisfactorily completed.
- The Department of Veterans Affairs will not be given an opportunity to suggest changes in the report.
- The names and affiliations of the report reviewers will be made public when the report is released.

Once the report is finalized and approved for public release, briefings and embargoed copies of report will be provided to the Department of Veterans Affairs and Congress just prior to public release of the report, which is planned for June, 2011.

Question 2: Please briefly summarize your recommendations regarding Blue Water Veterans as outlined in your *Veterans and Agent Orange Update 2008*, particularly regarding the definition of “service in Vietnam” and the pertinent findings of the 2002 Australian report (p. 564–566) [sic].

Response: The Committee for *Update 2008* was aware of the “boots on the ground” controversy associated with the *Haas* case. The definition of “service in Vietnam” has been a component of the deliberations of all Veterans and Agent Orange (VAO) committees. The Committee responsible for the first VAO report (1994) considered epidemiologic studies of both blue and brown water Navy personnel in their analysis of research on the health of Vietnam veterans. This approach to classifying Vietnam veteran status had been followed by all subsequent VAO committees for the biennial updates.

As detailed on pages 54–55 and 655–656 of *Update 2008*, the Committee explained that it was not aware of scientific information to merit changing its operational definition of “Vietnam service.” After obtaining an explanation of the physicochemical principles applicable to the 2002 Australian distillation study from Steven Hawthorne of the University of North Dakota’s Energy and Environmental Research Center, the Committee was satisfied that concentration of dioxin by shipboard preparation of drinking water constituted a possible route of exposure. The Committee noted that observed health outcomes in blue water Navy veterans (particularly non-Hodgkin’s lymphoma) are concordant with possible dioxin exposure. The Committee also remarked that admittedly limited measurements of serum TCDD levels indicate considerable overlap in the distributions for veterans who had been on Vietnamese soil and for those who had served elsewhere in Southeast Asia.

From the perspective of the VAO committee for *Update 2008*, adoption of a definition of “Vietnam service” in accord with the February 27, 2002 directive in VA’s M21–1 manual concerning BWN veterans for use in the Committee’s deliberations would represent a change from its established procedures without compelling supporting evidence and would not be consistent with the premise of giving the veterans the benefit of the doubt.

Question 2(a): Given your recommendation in your 2008 *Update*, do you think further study is needed on establishing the exposure of Blue Water veterans to Agent Orange?

Response: The Committee that prepared *Veterans and Agent Orange: Update 2008*, with its pre-existing familiarity with the general paucity of information concerning the exposure of individual veterans to the herbicides sprayed by the U.S. military in Vietnam, did not engage in exhaustive searches for any and all possible information specifically related to the BWN veterans. After seeking outside expertise, the Committee was satisfied that concentration of dioxin during shipboard preparation of drinking water was a possibility. In the absence of new evidence demonstrating that BWN veterans were definitively less exposed than all veterans with “boots on the ground” experience in Vietnam, who VA now regards as presumptively exposed to Agent Orange, the Committee for *Update 2008* did not see a rationale for altering the operational definition of “Vietnam service” used in the Veterans and Agent Orange series since release of the first report in 1994.

The study now being conducted at VA’s request by the new IOM committee on Blue Water Navy Vietnam Veterans and Agent Orange Exposure has as its sole purpose conducting a comprehensive search for all relevant information that might support or refute VA’s current manner of classifying veterans as “Vietnam veterans” with presumed possible exposure to Agent Orange.

Question 3(a): In accordance with a provision outlined in P.L. 110–389, what is being done to ensure the preservation of the Air Force Health Study (Ranch Hand) samples by the IOM’s Medical Follow-up Agency?

Response: Section 803 of P.L. 110–389—the *Veterans’ Benefits Improvement Act of 2008*—is entitled “Maintenance, Management, and Availability for Research of Assets of Air Force Health Study.” The law states that “[t]he purpose of this section is to ensure that the assets transferred to the Medical Follow-Up Agency from the Air Force Health Study are maintained, managed, and made available as a resource for future research for the benefit of veterans and their families, and for other humanitarian purposes.” It transfers the data and biologic samples collected during the course of the Air Force Health Study (AFHS) to the Medical Follow-up Agency (MFUA), and requests that MFUA

- maintain and manage these assets;

- conduct “such additional research on the assets . . . as the Agency considers appropriate toward the goal of understanding the determinants of health, and promoting wellness, in veterans”; and
- make grants for pilot studies in connection with this research; and
- “submit to Congress a report assessing the feasibility and advisability of conducting [further] research on the assets” at the end of trial period specified in the legislation.

The Department of Veterans Affairs was directed to supply funding for these activities in subsection (f) of the law.

Since the law went into effect, MFUA has:

- accepted custody of an electronic database containing the information collected from those AFHS participants who consented for their data be transferred to MFUA, and placed that database in secure storage;
- arranged with the U.S. Air Force’s 711th Human Performance Wing, Human Effectiveness Directorate, Biosciences and Protection Division, Applied Biotechnology Branch, located at Wright-Patterson AFB to hold and maintain the AFHS biologic samples in secure storage; and
- been negotiating with the Department of Veterans Affairs to provide the funding for the assets maintenance and research activities specified in subsections (d) and (e).

The negotiations with VA were still in progress as of 15 May 2010. In his 5 May testimony before the Committee, Joel Kupersmith, MD—Chief Research and Development Officer for VA’s Veterans Health Administration—stated:

To accomplish [the goals of P.L. 110–389], VA is contracting with IOM; to date, VA has met with IOM and has enlisted the assistance of VA’s Office of General Counsel and a contracting specialist. Ultimately, funds will be transferred from VA to the U.S. Air Force for the maintenance of the bio-specimens using a Military Interdepartmental Purchase Request.

MFUA hopes to conclude negotiations with DVA in the near future, receive the funding that will allow it to carry out the provisions of Section 803 in a timely manner, and then implement those provisions.

Question 3(b): Does the Medical Follow-up Agency need anything further from VA or Congress to preserve these specimens?

Response: MFUA believes that, once the funding for its activities is in place, it will be able to carry out the Congress’ intent to preserve the AFHS assets and promote research regarding them. It notes that the Congress anticipated that this funding would be made available at the beginning of FY 2009, stating in Section 803, subsection (d)(1):

The Medical Follow-Up Agency may, during **the period beginning on October 1, 2008, and ending on September 30, 2012**, conduct such additional research on the assets transferred to the Agency from the Air Force Health Study as the Agency considers appropriate toward the goal of understanding the determinants of health, and promoting wellness, in veterans. **[emphasis added]**

More than a year and a half has elapsed since then. It is not possible for MFUA to fulfill the mandates of the section in fewer than the 4 years the Congress specified in the subsection because time is required to determine whether the additional research called for is yielding information relevant to the determinants of health and promotion of wellness in veterans. If MFUA is to fulfill the mandates of section 803 it will be necessary to adjust both the funding years for the research and the due date for the report requested in subsection (e)(1).

Question 4: What is being done to further study the possible birth defects or developmental disease in the offspring of herbicide exposed veterans or even their children’s offspring (epigenerational [sic] effect of exposure)?

Response: Although VAO committees have repeatedly noted the great concern of Vietnam veterans about the possibility that their deployment (presumably because of possible herbicide exposure) may be responsible for health problems in their children (and now their grandchildren) and recommended that additional epidemiologic investigation be conducted, we are not aware that any such study of Vietnam veterans and their offspring is underway.

The Committee for *Update 2008* noted that recently explored epigenetic mechanisms might provide a previously overlooked means by which paternal transmission

of transgenerational effects could arise from exposure to components of the herbicides sprayed in Vietnam. Epigenetic modifications are chemical changes to DNA that do not involve base-pair alterations, but that are transmissible through cell division. The currently understood consequences of such modifications arising from gestational or postnatal exposure (i.e., not paternal transmission) involve transmission from an altered cell to an individual's own somatic tissues resulting in impacts on gene expression with potentially adverse effects in later life such as cancer, obesity, behavioral problems, etc. There is preliminary evidence that epigenetic modifications induced by some chemicals may persist through gametogenesis to produce transgenerational effects. As of *Update 2008*, toxicologic studies had not been published on the potential of any of VAO's chemicals of interest to produce epigenetic effects. The nature of dioxin's pattern of toxic activity through signaling pathways impacting gene expression, however, suggested to the Committee that it would be an appropriate target for such toxicologic investigation.

Epidemiologic studies of transgenerational effects, particularly by paternal transmission, are logistically extremely challenging, but protocols would not necessarily be altered by whether the underlying mechanism of action is hypothesized to be genetic or epigenetic.

Question 5(a): What is your charge as you begin to collect data and ramp up for your next Update in 2010?

Response: In accordance with P.L. 102-4, the Committee preparing *Update 2010* will "determine (to the extent that available scientific data permit meaningful determinations)" the following regarding associations between specific health outcomes and exposure to TCDD and other chemicals in the herbicides used by the military in Vietnam:

- whether a statistical association with herbicide exposure exists, taking into account the strength of the scientific evidence and the appropriateness of the statistical and epidemiological methods used to detect the association;
- the increased risk of the disease among those exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and
- whether there exists a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the disease.

Question 5(b): Are there any conditions to which you are paying special attention?

Response: As is the standard VAO procedure, the Committee for *Update 2010* will focus its deliberative efforts on health effects for which the peer-reviewed literature published in the last 2 years has provided new data related to exposure to the components of the herbicides sprayed in Vietnam that might result in a change in the health effect's category of association.

It is our understanding that VA is again requesting special attention to the possibility of adverse transgenerational effects occurring in the offspring of male Vietnam veterans.

Question 5(c): Is there any thing else you need from Congress to carry out your charge?

Response: VAO committees have recommended that additional epidemiologic studies of Vietnam veterans be facilitated since the original report was published in 1994. Data from such studies would greatly help future committees to draw conclusions on the three elements of the charge listed above. Because the publication period for *Update 2010* ends on September 30, however, newly initiated research will not have generated results for consideration in this biennial update.



Committee on Veterans' Affairs
Washington, DC.
May 10, 2010

Charles Marmar, M.D.
Chair, Department of Psychiatry
New York University Langone School of Medicine
550 First Avenue
OBV Building A, Rm. A645
New York, NY 10016

Dear Charles:

In reference to our full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

CW:ds

New York University Langone Medical Center
New York, NY.
June 18, 2010

Chairman Bob Filner
Committee on Veterans' Affairs
U.S. House of Representatives
One Hundred Eleventh Congress
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

Below please find my responses to the Post-Hearing Questions following the May 5, 2010, full Committee Hearing entitled, "National Vietnam Veterans Longitudinal Study: Where Are We?"

Question 1: How important is it that the NVVLS be conducted:

- It is of exceptionally high importance in order to determine the longitudinal course, mental health consequences, family impact, and medical consequences of war zone related PTSD.
- The NVVLS is the only nationally representative sample of Vietnam veterans' comprehensive readjustment findings at baseline during 1986 and 1987, permitting a careful analysis of risk and resilience for long-term adverse health consequences.
- The findings from the NVVLS will inform policy for the mental health and family adjustment of Iraq and Afghanistan veterans.
- Determining the long-term adverse mental health and physical health consequences of Vietnam war service will allow the DoD and the VA to develop prevention strategies to preserve the resilience of Iraq and Afghanistan veterans and their families.

Question 2: Would you like to comment on the VA's contention that the NVVLS will not adequately address questions about, "the mental or physical health status of the Vietnam veteran population?"

- The majority of participants will be locatable, interviews will be conducted by telephone, and mental and physical health status will be accurately determined in a nationally representative sample of Vietnam veterans.
- Studies currently in progress supported by VA, including the twin study and women veterans study, are important, but they will not address the fundamental question of the rates of mental health and physical health problems in a representative sample of Vietnam veterans.

Question 3: I found interesting your comments that the NVVRS, if complemented with the NVVLS, will provide critical lessons learned for the long-term readjustment needs of OEF and OIF veterans. Please elaborate on that point:

- The NVVLS will provide a roadmap defining resilience and vulnerability of those exposed to war zone stressors.
- This information will inform novel strategies for mitigating the effects of PTSD, depression, alcohol and substance abuse, and family stress, as well as adverse physical health problems, including cardiovascular disease and risk for early onset dementia, for OEF and OIF veterans.

If you have any additional questions, or need further clarification on these responses, please feel free to contact me at 212-263-6214 or via email to my assistants: Ellen.lerner@nyumc.org or Desiree.Collier@nyumc.org.

Sincerely,

Charles R. Marmar, M.D.
Professor and Chair
 Department of Psychiatry

Committee on Veterans' Affairs
 Washington, DC.
 May 10, 2010

Gene L. Dodaro
 Acting Comptroller General
 U.S. Government Accountability Office
 441 G Street, NW
 Washington, DC 20548

Dear Gene:

In reference to our full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

Bob Filner
Chairman

CW:ds

Testimony on May 5, 2010:

**“Health Effects of the Vietnam War—The Aftermath”
VA Health Care: Progress and Challenges in Conducting the
National Vietnam Veterans Longitudinal Study (GAO-10-658T)**

Question 1: When a Federally-funded study is conducted solely by a contractor, is it typical for Federal agencies to require that the contractor give the agency the identifying information of the participants in the study?

Answer: Not for studies like the NVVLS.

- Methodologists we talked with said that it is typical for the contractor to ensure confidentiality to participants, especially for studies funded by Federal Government agencies, because many people distrust government agencies. Identifying information is not usually provided in these cases.
- The methodologists and researchers we spoke to did not know why VA would want that information.

Question 2: Is it important for agencies such as VA to contract out research studies on sensitive issues such as PTSD?

Answer: For studies like the NVVLS, Yes.

- Again, because of distrust that many people have for Federal Government agencies, such as VA and DoD, independent third parties—who can assure confidentiality among participants—may be in a better position to elicit more open and accurate answers on sensitive issues.

Question 3: What type of information could the NVVLS provide?

Answer: A number of things:

- It would provide information on the long-term-course and medical consequences of PTSD;
- It would provide information on the services used by veterans with PTSD and the effect of those services in treating PTSD;
- And, it would provide information on particular subgroups, such as Hispanic and black males, women, and veterans with service-connected disabilities to help discern whether those veterans are at greater risk of chronic or more severe problems with PTSD.

Question 4: Could the NVVLS provide information related to Agent Orange exposure and other health effects from the Vietnam War?

Answer: The NVVLS could provide long-term health information for those Vietnam-era veterans that may have been exposed to Agent Orange.

- The contractor for the NVVLS could include questions related to Agent Orange as part of the analysis, according to researchers and methodologists we talked with.

Question 5: Based on the work you have done, is VA doing everything they can to complete the NVVLS in a timely manner?

Answer: That’s hard to say, since we don’t have access to internal VA discussions on this matter.

- If the past is any indication, the answer is no. It has been 7 years since the failed NVVLS attempt, and as recently as last year, VA has asked this committee to accept the Twin and Women Veteran studies as substitutes for the NVVLS. These facts speak volumes about VA willingness to get the NVVLS moving.
- Looking forward, a couple of things are important to do expeditiously:
 1. First, VA has not yet selected a contractor.
 2. Second, after a contractor is selected, VA expects the contractor to assess the feasibility of the NVVLS, given the challenges VA has identified. It is very important that this phase of the study is done thoughtfully and thoroughly.

Question 6: Do the twin and the women’s studies meet all the requirements of the Veterans Benefits and Health Care Improvement Act of 2000?

Answer: Not entirely.

The law clearly states that VA must contract with an appropriate entity to conduct a follow-up study to the NVVRS using the same data base and sample.

- Neither the twin nor women’s study will use the complete NVVRS data base and sample.

- The twin study sample is limited to male twins and the women's study sample is comprised of only women.
- The women's study will not provide information on the long-term course of PTSD.

Committee on Veterans' Affairs
Washington, DC.
May 10, 2010

Richard F. Weidman
Executive Director for Policy and Government Affairs
Vietnam Veterans of America
8719 Colesville Road
Silver Spring, MD 20910

Dear Rick:

In reference to our full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

Bob Filner
Chairman

CW:ds

**Vietnam Veterans of America (VVA)
Questions and Answers from the May 5, 2010 Hearing
From the Honorable Bob Filner**

Question 1: Mr. Weidman, you lay out a strong case for the importance of the NVVLS to providing quality health care to veterans of both the Vietnam War and current and future conflicts. What do you view as the most important benefits that this study would provide?

Response: Properly completing the NVVLS will prove to be valuable in many ways. First, it will give us a good picture of the arc of psychosocial readjustment and mental health of the last large cohort of combat veterans prior to the current wars. This is important not only to be able to plan for the medical needs of the Vietnam cohort, but to do long range planning for the needs of the newest combat theater veterans are likely to be.

Secondly, there has always been a need for a robust epidemiological study of the overall health of the Vietnam generation of veterans, particularly how the combat theater veterans are doing in comparison to those who did not serve in a combat theater and how they compare to their non-veteran peers. This kind of epidemiological work is just basic good scientific practice, particularly in a democracy where you have citizen soldiers. The Australians have done three complete universe epidemiological studies on all branches of their Armed Services who served in the Vietnam Era, and are working on their fourth such study. That is how you pick up on anomalies that then should be pursued by specific scientific studies to discover why there is a higher incidence of a disease, malady, or condition that is higher than would be expected in this population.

Third, the Institute of Medicine (IOM) of the National Academies of Science (NAS) has noted as they released their biennial reviews of Agent Orange pursuant to the requirements of Public Law 102-4, the Agent Orange Act of 1991, that the one major thing they were lacking to do their job correctly was a robust epidemiological

study or Vietnam veterans and their families. While the NVVLS does not address the families (progeny), it is probably as close as we in America are going to get to a complete epidemiological study of Vietnam veterans.

Fourth, all of the above should guide the military in taking steps in the future to better protect our servicemembers from harm while they still accomplish the mission.

Question 2: Mr. Weidman, both your testimony and that of GAO notes that VA's requirement that the agency or organization contracted with to conduct the NVVLS disclose the identifying information of participants is not in keeping with standard scientific protocol. Do you believe that this requirement could dissuade some original participants from the NVVRS from participating in the NVVLS?

Response: We believe that this requirement for disclosing the participant identifiers will doom the effort to complete the NVVLS project. The Research & Development (R&D) personnel know this, which is why they inserted it. They used the same sneaky and dishonest method to kill the Congressionally mandated brain study of Gulf War I veterans being done by Dr. Robert Haley in Texas.

Frankly, given the VA's terrible track record of using such confidential information in an improper manner, VVA does not think that any objective person should be surprised that veterans would balk at "writing the VA a blank check" to use this info. Such disclosure as they are asking of these participants is not only giving permission to have access to information shared in this round with whoever at VA has a whim to do so, but to have the same wide open access to all information shared 25 years ago in the original study. This flies in the face of commonly accepted scientific practice for human subject research guarantees of confidentiality that are routinely approved. Individual identifiers are not needed for any valid scientific reason. Frankly, why would they want this info? For I can assure you that if they have it, somebody at VA will sooner or later decide to use this info for some improper usage, probably against the individual veteran, without regard to the fact that the veteran may have acted in good faith in every facet of his/her behavior.

What is puzzling to us is why the Secretary of Veterans Affairs listens to these people. These people have no business leading any organization because of their lack of integrity and veracity, much less the R&D section of VA that should be devoted to helping improve the care and the health of those who have served our Nation well in the Armed Services of the United States.

We have repeatedly explained to the Secretary and his team (and The White House) that at VVA we usually do not get involved with personalities or personnel decisions. However, in this case the lies and other dishonest acts are just plain unacceptable behavior, and that whole leadership team at R&D within VA needs to be replaced with people of integrity. Fortunately there are many people who are much more talented and qualified for these positions than the current incumbents who could be attracted to come to VA. There are many that would step up to the challenge who are able to do what all good scientists do: seek the truth wherever it may lead, and then speak the truth about it to all in an open and transparent way. Dishonesty and lying by public officials is intolerable. In medical scientists it is both outrageous and immoral. We need new leadership at VA R&D.

Question 3: You have stated that the "Twins Study" and other proposed alternatives to the NVVLS are not adequate replacements. What additional benefits does the NVVLS provide, in comparison to these alternative studies?

Response: The so-called "Twins Study" that was done by the Centers for Disease Control (CDC) is not a statistically valid random sample that would allow one to form conclusions that would apply to all Vietnam veterans in the country. Rather, the "Twins Study" is based on a sample of convenience, meaning that it consists of sets of identical twins, who opted to volunteer to participate in the study, where one twin served in the U.S. military in Vietnam, and the other twin served in the U.S. military but did NOT serve in Southeast Asia. This sample is virtually all Caucasian, with fewer than a dozen black or Hispanic veterans combined, and no women whatsoever. All of the money spent using this sample would not lead to answering the questions at hand about all Vietnam veterans, much less very important subsets of the population (e.g., women veterans or Hispanic veterans). Neither the "Twins Study" nor any other "alternative" studies that VA said would suffice are statistically valid random samples of men and women who served Vietnam, nor are these other studies "oversampled" in a way that is necessary in order to be able to draw valid conclusions about the subsets to the overall population.

ONLY the NVVLS existing pool of human subjects can be used for the purpose of being able to draw conclusions about the overall population of Vietnam veterans as compared to to others their age, and the only one where you can reach valid con-

clusions as to the health of subsets of the population. Further, The NVVLS is the only study population where the beginning point dates back 25 years, and the only one that has both a control group of military personnel who served in the era but not in Vietnam, as well as a second control group of those the same age who did not serve in the military at all. For all of these reasons, it is imperative that VA move forward with getting the NVVLS done, and done properly.

Committee on Veterans' Affairs
Washington, DC.
May 10, 2010

Steve Robertson
Director, National Legislative Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Steve:

In reference to our full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

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Sincerely,

Bob Filner
Chairman

CW:ds

American Legion
Washington, DC.
June 21, 2010

Honorable Bob Filner, Chairman
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

Thank you for allowing The American Legion to participate in the Committee hearing on Health Effects of the Vietnam War—The Aftermath on May 5, 2010. I respectfully submit the following in response to your additional questions:

- 1. VA has expressed concerns about the feasibility of mustering a statistically significant sample size of participants in the NVVRS; not just due to difficulties in locating all of the participants, but also to concerns that some of the original participants may be reluctant to participate. Do you share their concern that reluctance on the part of participants in the NVVRS may be problematic?**

Mr. Chairman, The American Legion does share a concern if there are no original participants to take part in the study. However, we do feel that VA should conduct the study, and as long as a representative sample is found the results would be valid. During the 2001 NVVLS study, the researchers estimated that 8.5 percent of the Vietnam-era veterans who originally participated in the first NVVRS, had died. Therefore we can anticipate a significantly reduced number of participants. We rec-

ommend that VA provide the number of remaining original participants and request their participation in the upcoming study.

In conclusion, The American Legion again applauds the addition of a consent form and VA's promise that study participation will not affect the participants' VA benefits or VA health care; however, we also have further concerns over other language in the form or lack thereof. Left out of the consent form was the lack of assurance of confidentiality of the veterans identifying information. This could make potential veteran participants, to include original participants, reluctant to participate in the upcoming study; which may in turn invalidate the study.

2. Do you share GAO's concerns about VA's requirements that the NVVLS contractor provide them with the identifying information of participants in the study?

It is The American Legion's belief that the identifying information should be used for conducting the *NVVLS study only*. According to researchers and methodologists, to encourage participation for previous NVVRS participants, veterans were assured confidentiality of their identifying information. This confidentiality served as a factor to motivate veteran participation in the past and should be included on the upcoming NVVLS consent form.

VA's NVVLS consent form will lack assurances of confidentiality, because it states VA will in fact take possession of study participants' identifying information. We also share concerns that this may minimize veteran participation in the study.

Thank you for your continued commitment to America's veterans and their families

Sincerely,

Joseph Wilson, Deputy Director
Veterans Affairs and Rehabilitation Commission

Committee on Veterans' Affairs
Washington, DC.
May 10, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled "National Vietnam Veterans Longitudinal Study: Where are we?" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

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Sincerely,

Bob Filner
Chairman

CW:ds

Questions for the Record
The Honorable Bob Filner, Chairman
House Committee on Veterans' Affairs
Health Effects of the Vietnam War—The Aftermath
May 5, 2010

Question 1: What is the current state of the NVVLS?

Question 1(a): Specifically, it seems that the study is not progressing as originally planned. According to the GAO report, VA confirmed that it would release the request for proposals in spring 2010, and it is already May 5 and a request for proposals has not been released. What are the causes of these delays and what is VA's plan to move forward with the NVVLS in a timely manner?

Response: The solicitation for the National Vietnam Veterans Longitudinal Study (NVVLS) contract was released on May 26, 2010. Review of proposals will take place in July 2010, and the award recommendation should be completed in August 2010. All of these components meet the projected timeline.

Question 2: Your testimony states that the NVVLS would not adequately address questions about "the mental or physical health status of the Vietnam Veteran population."

Question 2(a): Specifically, which components of mental and physical health do the parameters of the NVVLS fail to sufficiently address? Please explain why VA believes that the proposed alternative studies would better address these questions.

Response: We believe that as the NVVLS, is one single study of an observational nature, it would not be sufficient to fully understand the mental and physical health of the Vietnam era population. VA has sponsored many studies of the Vietnam Veteran population, including two large studies currently being conducted: Cooperative Studies Program (CSP) #569, A Twin Study of the Course and Consequences of Post Traumatic Stress Disorder in Vietnam Era Veterans, and CSP #579, Health of Vietnam Era Veteran Women's Study. In addition, other studies are focused on improving the understanding of exposures and treatment trials. Together with NVVLS, the body of research supported by VA will provide a great deal of information about the status of the Vietnam Veteran population's mental and physical health.

Question 3: You note that the Scientific Panel of the Integrated Project Team has found that the NVVRS was not designed to accommodate a follow-up study and that the potential for statistical bias must be addressed. Please elaborate on this concern.

Response: The National Vietnam Veterans Readjustment Study (NVVRS) population has not been maintained as a cohort for long-term follow up. At the initiation of a long-term study, there are plans to follow the individual participants from the initiation of the longitudinal study and over the ensuing years. Participants are contacted regularly, contact information is kept up to date, and information about activities regarding the cohort is provided using a variety of communications such as newsletters. For example, the Vietnam Era Twins Registry (established in the 1980s) sends out newsletters, and the twins are contacted on an ongoing basis for participation in studies sponsored by the Registry, making it a very well studied cohort. This did not occur with the NVVRS, which was conducted at a single point in time as a cross-sectional study.

Question 4: The Integrated Project Team has also noted the need to transfer data from the NVVRS to the NVVLS. Given that this data was initially gathered in 1988, has it been digitized?

Question 4(a): If not, what challenges will VA face in doing so?

Response: VA, through the Office of General Counsel, has recently received confirmation that the NVVRS data will be transferred smoothly to the awarded contractor.

Question 5: A third challenge identified by the Integrated Project Team is the potential difficulty in getting the original cohort of Veterans to participate in the NVVLS.

Question 5(a): Was this a challenge during the NVVRS?

Question 5(b): If so, how did VA address it then?

Question 5(c): If not, why does VA believe it may be a challenge now?

Response: While we do not know whether the participation rate was a challenge in the NVVRS, it is a challenge now because the NVVRS is a “closed cohort,” meaning the intent of the NVVLS is to re-assess the exact same participants in the NVVRS. After locating the individuals, if living, the NVVLS contractor will then determine their willingness and ability to participate in NVVLS.

Question 6: What is your plan for completing the NVVLS if the chosen contractor can not get enough NVVRS participants to participate in the study?

Response: One part of the contract will include a feasibility phase to determine the estimated response rate for the NVVRS participants and pursue as much of the study as possible based upon information from this phase. If insufficient participation rates are estimated, it will adversely impact the scientific questions being asked and the information gathered may not be sufficient to draw meaningful conclusions for all of the components mandated in Public Law (P.L.) 106–419. The study plan will be to first assess feasibility, and then determine what scientific goals can be met based on the response rate. Planned subgroup analyses could be affected. For example, if the response rate is lower in the subgroup of NVVRS women, the findings in NVVLS might not be meaningful as the NVVRS initially included a lower number of women than men. In comparison to the NVVLS, the VA women’s Vietnam Veterans study (CSP #579) may provide more meaningful data from which to draw conclusions given that the women’s study will attempt to survey thousands of women.

Question 7: Why does VA want the identifying information of the NVVRS participants?

Response: VA plans to establish the NVVLS cohort under the auspices of research, specifically for the purpose of additional study. Ultimately, the security of these data is VA’s responsibility, not that of any contractor as stipulated in 44 U.S.C. §3101—Records management by agency heads; general duties, which states: “The head of each Federal agency shall make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the agency and designed to furnish the information necessary to protect the legal and financial rights of the Government and of persons directly affected by the agency’s activities.” Since these data are owned by the Federal Government, it needs to be legally under our control for the NVVLS and for future purposes as consented to by the participants.

Question 7(a): Is VA concerned that asking for this information from participants may dramatically impact the participation rate of the study?

Response: VA does not have any information suggesting this would have a dramatic impact on the participation rate.

Question 7(b): How would obtaining this information be perceived by contractors proposing to conduct the NVVLS, or by the previous contractor, the Research Triangle Institute, who currently holds the data?

Response: VA’s contracting officer and attorneys will work with RTI for the transfer of data, which is necessary for the new contractor. The new contractor needs the information in order to contact the exact same participants. RTI has stated that it will provide the information to the new contractor once the contract is awarded by VA.

Question 8: In 2005, the Health and Human Services Office of Inspector General found that the Research Triangle Institute provided VA with deliverables from the 2001 NVVLS attempt that provided detailed information on an approach for a follow-up study to the NVVRS. Has VA been using these deliverables to help plan the NVVLS?

Response: No, the 2001 deliverables have not been used. The solicitation was developed in conjunction with scientific expert consultation; many of these scientists were involved in NVVRS.

Question 9: Why does VA plan to fund the NVVLS from the medical care appropriation instead of from the medical and prosthetic research appropriation?

Response: ORD will be funding this program from the Medical and Prosthetic Research appropriation.

Question 10: After the 2001 NVVLS attempt was terminated in 2003, why did it take ORD so long to restart the study?

Response: NVVLS was stopped at the direction of the Secretary in 2003 due to contracting and study management irregularities and only restarted in September 2009, by the Secretary. Since September 2009, VA ORD has been working with our attorneys and contracting office to carefully develop the Statement of Work and the solicitation, which was released on May 26, 2010 and which will be awarded by the end of August 2010.

Question 11: Please elaborate on the specific problems that VA encountered in 2001, when the contract stipulating that the Research Triangle Institute conduct the NVVLS was terminated.

Question 11(a): How will VA learn from the lessons of this failed attempt to conduct the NVVLS and adapt to ensure that similar issues do not arise again?

Response: The contracting procedures and policies for VA have changed since 2001 and VA has set in place requirements for proper contracting to avoid the issues encountered with the prior attempt to conduct NVVLS. We, therefore, believe that the considered development of the current NVVLS solicitation and statement of work will result in successful implementation of the study. The NVVLS contract will have performance measures in place that will be followed throughout the contract performance period to ensure that similar issues do not arise again.

Question 12: Do you think the PTSD prevalence rates in Vietnam Veterans have improved over time?

Response: Numerous studies have examined post-traumatic stress disorder (PTSD) prevalence in Vietnam Veterans, with other studies reporting lower PTSD prevalence estimates for Vietnam Veterans than NVVRS reported. Vietnam Veterans still have health care needs related to PTSD that may be influenced by factors such as better case recognition (improved diagnostic methods over time), or a greater understanding, willingness, and interest among Veterans with symptoms to come forward for care or compensation. Studies underway at this time should result in a better understanding of the natural history of PTSD.

Question 12(a): How has VA helped Vietnam Veterans, particularly those with issues such as PTSD?

Response: The treatment of PTSD and other war-related disorders is the highest priority for VA health care. VA has the responsibility for providing clinical care and benefits for our Nation's veterans. VA operates an internationally recognized network of more than 200 specialized programs for the treatment of PTSD through its medical centers and clinics. Every VA Medical Center (VAMC) has outpatient PTSD specialty capability and, to address cases where PTSD might be complicated by a substance use disorder, each team has an Addictive Disorders Specialist associated with it.

PTSD programs provide a comprehensive continuum of care from outpatient PTSD Clinical Teams (PCT) through specialized inpatient units, brief-treatment units, and residential rehabilitation treatment programs. In addition, there are increasing numbers of specialized resources within PTSD programs to meet special needs such as Veterans who are survivors of Military Sexual Trauma.

VA has increased mental health staff by 5,075 over the last 3 years through Mental Health Expansion Initiative (MHEI) funds. This includes 340 new FTE for PTSD programs.

VA has always had a commitment to provide the most effective, evidence-based care for PTSD. VA has implemented significant training initiatives to ensure that VA clinicians receive training in state-of-the-art treatments for PTSD. VA has trained more than 2,800 VA clinicians in the use of Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). CPT and PE are evidence-based therapies cited by the Institute of Medicine Committee on Treatment of PTSD, proven to be effective treatments for PTSD. VA's treatment approaches for PTSD are described in the Joint VA/DoD PTSD Clinical Practice Guideline, originally published in 2004 and currently being updated.

With regard to the treatment of mental disorders, including PTSD, VA's orientation towards care is based on the concepts of Rehabilitation and Recovery. Rehabilitation means that in addressing mental health problems one looks at strengths as well as symptoms and deficits in functioning, just as one does in rehabilitation from physical injuries or medical/surgical health problems. Recovery involves including the patient and their significant others in active planning and implementation of their care.

The number of Vietnam Veterans treated for mental disorders has increased from 162,127 unique Veterans in FY 2002 to 464,900 unique Veterans in fiscal year (FY)

2008, the last complete year for which these data are currently available. The number of Vietnam Veterans treated in specialty mental health services has increased from 90,000 in FY 1997 to 210,000 in FY 2007. In FY 2007, Vietnam Veterans represented 67 percent (210,000 of 310,000) of Veterans receiving specialty mental health services for PTSD.

Question 13: How does VA perform outreach to advise Vietnam era Veterans that they are eligible for a free Agent Orange Registry examination?

Response: VA has several mechanisms to conduct outreach to Agent Orange Veterans. Most importantly every VAMC has a designated Environmental Health Coordinator who is the point of contact for combat Veterans with concerns regarding environmental exposures. This person is knowledgeable about all of the Registry programs and can schedule appointments for Registry examinations with designated Environmental Health Clinicians. The Registries are also promoted through print media such as program specific posters, pamphlets, the Agent Orange Review newsletter, and Internet resources including a social marketing plan and a dedicated Agent Orange Web site located at: <http://www.publichealth.va.gov/exposures/agentorange/index.asp>.

We also routinely present to VA's VSOs monthly meeting regarding updates to the registry program.

Question 13(a): You noted that VA offers "an array of resources to providers" regarding concerns and treatments related to Agent Orange. Please discuss in greater detail how VA works with these providers and how this fits into the broader outreach plan for Vietnam Veterans.

Response: VA has developed a series of educational modules, titled "The Veterans Health Initiative," which includes a volume dedicated to Veterans and Agent Orange. This compendium provides background information on the laws, science and related practice concerns relative to the clinical treatment of Vietnam Veterans. Also, Environmental Health Coordinators and Clinicians are present in VAMCs to assist providers who may have questions while caring for Vietnam Veterans. The Office of Public Health and Environmental Hazards (OPHEH), Environmental Health Strategic Health care Group, maintains a relationship with the Environmental Health personnel in the field through quarterly teleconferences which provide updates on issues relevant to delivering health care to the combat Veterans under VA's care. OPHEH staff members with significant experience in occupational and environmental medicine are available to answer queries from frontline providers. Non-VA clinicians will be able to obtain the content of this training through a PDF document, posted on OPHEH Web site. In addition, we have established a VHA charter review committee which includes Employee Health Specialists, subject matter experts from OPHEH and Patient Care Services. Further, there is coordination with the Office of Academic Affiliations to ensure these very important training tools are available for all clinicians (VA, non-VA, residents and Fellows) who care for Veterans regardless of the era in which they served.

Question 14: Why did VA change its regulations in 2002 to require a "foot on land" occurrence, thereby excluding Blue Water Veterans from the presumption of service-connection for herbicide exposure recognized conditions?

Response: Under the Agent Orange Act of 1991 (codified in pertinent part at 38 U.S.C. § 1116(f)), the statutory presumption of herbicide exposure applies to Veterans who served "in the Republic of Vietnam." Since 1993, VA's regulation implementing the Agent Orange Act has consistently provided that "Service in the Republic of Vietnam includes service in the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam." 38 CFR § 3.307(a)(6)(iii). That regulation reflects VA's view that Congress intended the presumption of exposure to apply to Veterans who were present on land or on the inland waterways of Vietnam, where herbicides were applied.

In *Haas v. Peake*, 525 F.3d 1168 (Fed. Cir. 2008), the United States Court of Appeals for the Federal Circuit noted that, although there was some ambiguity in the language of VA's regulation, VA had consistently explained its view that the governing statute required service on land or on the inland waterways of Vietnam, and the court concluded that VA's position was a reasonable interpretation of the statute. As the court noted, VA's interpretation of the statute was explained in General Counsel opinions and *Federal Register* notices in 1997 and 2001.

In 2002, the Veterans Benefits Administration (VBA) revised the language in its "Adjudication Procedures Manual M21-1," an internal manual providing instructions to VA adjudicators, to more clearly explain its interpretation of the governing

statute as requiring service on the land or inland waterways of Vietnam. As the Federal Circuit found in *Haas*, this 2002 revision of the manual was not a change in VA's regulations, nor was it a change in VA's longstanding interpretation of the governing statute.

It should be noted that VA interprets the governing statute to mean only that Veterans who served solely in offshore waters, where herbicides were not applied, are not presumed to have been exposed to herbicides. However, if such a Veteran alleges exposure to herbicides, VA will develop the evidence to determine if herbicide exposure may be established. If VA finds that the Veteran was exposed to herbicides, the Veteran is then entitled to the presumptions of service-connection for any conditions VA recognizes as being associated with herbicide exposure.

Question 15: Is VA aware of the findings in the studies conducted by the Australian government whereby it was determined that Blue Water Veterans in the Australian Royal Navy were Agent Orange exposed from use of contaminated sea water and it was likely exacerbated through the ship's water distillation process? If so, why does VA continue to require a "physical foot on land occurrence" in Vietnam to prove herbicide exposure for our combat Veterans who served in identical situations?

Response: VA is concerned about Blue Water Navy Veterans. Prior to the release of Update 2008, VA had entered into discussions with National Academy of Science to undertake a comprehensive evaluation of the potential for herbicide exposure among U.S. blue-water Veterans, taking into account the Australian study and all other relevant information. VA entered into a contract with the Institute of Medicine (IOM) to provide a careful assessment of the exposure potential for U.S. Veterans aboard naval vessels in the coastal estuaries and waters off the coast of Vietnam. The IOM unexpectedly addressed that issue in Update 2008, without the benefit of a charge from VA and, therefore, did not address significant questions that VA has determined are central to a determination on this important issue. Accordingly, VA intends to proceed with its ongoing contract to obtain a sufficient analysis of the scientific issues based on a thorough review of the scientific and medical literature relevant to the matter. VA has specifically asked IOM to provide an assessment of the relevance and significance of the findings of Australian studies of exposure of naval personnel to the exposure experience of Blue Water Navy personnel who served in the waters off the coast including, but not limited to, ingestion of distilled sea water. VA has asked IOM to specifically address in its review comparisons of those who served in the Blue Water Navy with those who served in the Brown Water Navy, and those who served "boots on the ground." VA has also asked the IOM Committee to evaluate a wide range of exposure mechanisms including the potential for concentrating toxins in drinking water, airborne exposure from drift of spray paths, contamination of food, and contaminated soil.

Question 16: In light of the IOM's recommendations in Update 2008 in which it concluded that Blue Water Navy personnel should not be excluded from the set of Vietnam-era Veterans with presumed herbicide exposure and that "service in Vietnam" should be more broadly defined to include Blue Water Veterans to comport with the epidemiologic evidence, does VA plan to continue to deny presumptive service-connection for these Veterans?

Response: VA has contracted with IOM to better understand the exposure scenarios of those in the Blue Water Navy when compared to Veterans who served in other settings. The IOM review will help to clarify the relevance and significance of the Australian Royal Navy study findings to the experience of U.S. Navy personnel. The Australian Royal Navy study findings must be considered in the context of all other evidence regarding exposure potential for U.S. military personnel in order to assess the body of scientific findings before a judgment regarding presumption can be made.

Question 17: Blue Water Veterans have been included in all of the IOM Agent Orange Updates. Will VA include Blue Water Veterans in the NVVLS study and any future Vietnam veteran studies it conducts?

Response: Blue Water Veterans may be included in the NVVLS if they were participants in NVVRS; approximately 350 Navy participants completed NVVRS. It is not known how many would have been Blue Water Veterans.

Question 18: In light of the recommendations made by the IOM in its 2008 Update concerning Blue Water Veterans, does VA's request for an additional Blue Navy study by the IOM (due in 2011) contravene or at the very least frustrate con-

gression intent outlined in P.L. 102-4 for these Veterans? What is VA's intent for requesting this separate study?

Response: VA has contracted with IOM to better understand the exposure scenarios of those in the Blue Water Navy when compared to Veterans who served in other settings. The IOM unexpectedly addressed that issue in Update 2008, without the benefit of a charge from VA, and therefore, did not address significant questions that VA has determined are central to a determination on this important issue. Accordingly, VA intends to proceed with its ongoing contract to obtain a sufficient analysis of the scientific issues based on a thorough review of the scientific and medical literature relevant to the matter. The IOM review will help to clarify the relevance and significance of the Australian Royal Navy study findings to the experience of U.S. Navy personnel. The Australian Royal Navy study findings must be considered in the context of all other evidence regarding exposure potential for U.S. military personnel in order to assess the body of scientific findings before a judgment regarding presumption can be made.

Question 19: As recommended by the IOM in Update 2008, does VA plan to evaluate the possibilities for studying health outcomes among Vietnam-era Veterans by identifying and linking Vietnam service in the computerized index of records within DoD and VA to assemble epidemiologic information.

Response: The IOM's Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides—"Veterans and Agent Orange Update 2008"—has recommended that VA undertake studies that utilize existing data resources. To satisfy this recommendation, VA will undertake an evaluation of health care utilization at VAMCs by beneficiaries identified on our roster of deployed Vietnam Veterans. This will provide a snapshot of the diagnoses assigned and procedures used by those Veterans who obtain care at VA facilities. The methodology for such a study might include a comparison with non-deployed Vietnam-era Veterans who have used our facilities to determine the potential contribution of deployment on the health and illness experience of Veterans seen by VA. VA will conduct a mortality study of deployed Vietnam Veterans to determine cause of death. This will allow for comparison with other population samples of Veterans and non-Veterans to assess differences that may be attributed to service in Vietnam.

Question 20: What is being done to further study the possible birth defects or developmental disease in the offspring of herbicide exposed Veterans or even their children's offspring (epigenerational effect of exposure)?

Response: The IOM Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides—"Veterans and Agent Orange Update 2008"—concluded "that it is considerably more plausible than previously believed that exposure to herbicides sprayed in Vietnam might have caused transgenerational effects." The Committee recommended "that toxicologic research be conducted to address and characterize TCDD's potential for epigenetic modifications" and stated that it "is more convinced that additional epidemiologic study would be a worthwhile investment of resources." The Committee suggested that epidemiologic studies of adult offspring would require "the development of innovative techniques and protocols," but provided no guidance regarding methodology. Also, the Committee did not suggest what specific health endpoints might be observed in subsequent generations.

Additional challenges of such a study include: tracking and locating subjects across multiple generations as there is no existing list of offspring of herbicide exposed Veterans; securing informed consent for a project of this nature; assessment of exposures to herbicides during each individual's life; and, accounting for diverse health outcomes. Even with a successful effort to contact and enroll individuals into a study, there would not likely be a sufficient number to allow for scientifically valid estimates of the trans-generational effect of paternal exposure.

Recognizing these significant challenges, VA will review this issue over the next 6 months and consider various research strategies regarding the potential for paternally mediated trans-generational epigenetic effects in the offspring of herbicide exposed Vietnam Veterans that is consistent with available resources and priorities.

Question 21: What other plans does VA have to ensure the collection of longitudinal information of Vietnam-era Veterans?

Response: The Office of Research and Development is continuing to follow a cohort of Vietnam era male twins who participate in the Vietnam Era Twins Registry. Multiple studies have been conducted on these twins over the past 25 years, with over 130 scientific publications to date. Many of these have focused on PTSD—examining environmental and genetic factors, as well as pre-disposing risk factors

such as early trauma exposure. More recently, samples from the cohort have participated in studies focused on genetic relationships between heart rate variability and depression.

Committee on Veterans' Affairs
Washington, DC.
May 18, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled "Health Effects of the Vietnam War—The Aftermath" on May 5, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

Bob Filner
Chairman

CW:ds

Questions for the Record
The Honorable Deborah L. Halvorson
House Committee on Veterans' Affairs
Health Effects of the Vietnam War—The Aftermath
May 5, 2010

Question 1: What are we doing to make sure that veterans are aware of the illnesses that are listed as presumptive?

Response: The Veterans Benefits Administration (VBA) continually provides outreach to Veterans with presumptive disabilities or to those with military service that tends to lead to presumptive illnesses. In addition to traditional methods of delivery, such as mailings, pamphlets, Federal Benefits book, and fact sheets, VBA is also employing newer communication venues to include Web and social media outlets, such as Facebook and Twitter.

VBA has taken a proactive approach in targeting these Veterans. In October 2008, VBA identified more than 28,000 Vietnam Veterans through the Veterans Health Care system that had been diagnosed with disabilities presumed related to Agent Orange exposure. These Veterans were sent special outreach letters informing them of the benefits for which they may be entitled.

In partnership with VHA and Office of Public Health and Environmental Hazards, VBA provides content for newsletters related to Agent Orange, Gulf War service, radiation exposure, and service in the current conflicts in Afghanistan and Iraq. These newsletters, which may be received via mail, email, or reviewed online are published two to three times annually and keep interested Veterans updated on new medical studies, changes in benefits, and other related information.

Question 2: Why isn't compensation retroactive to the date the Veteran is diagnosed with a presumptive illness, instead of the date the claim is filed?

Response: Effective dates for beginning distribution of Department of Veterans Affairs (VA) compensation payments based on service-connected disabilities are gov-

erned by 38 U.S.C. § 5110. This statute requires that: “Unless specifically provided otherwise . . . the effective date of an award based on . . . [a disability claim] . . . shall not be earlier than the date of receipt of application therefore.” This is a Congressional mandate that VA must follow. It applies to claims for presumptive conditions as well as all other claimed disabilities. There are exceptions, as for example, when a claim is filed within 1 year of separation from service for certain presumptive conditions, the effective date may go back to the day following separation. However, it is clear that Congress did not intend compensation payments to be retroactive to the date the Veteran was diagnosed with a presumptive illness.

